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ABSTRACT

The report provides Indian and Migrant Program Division managers and specialists in each of the 5 Head Start component areas with a comprehensive picture of the 43 home base learning centers operating between October 1978 and May 1979, with a total enrollment of 3,108 migrant children. Using data collected from the Head Start and center directors, the staff responsible for service delivery in each program component, and the parents, this Phase I report presents detailed, component-specific information on program activities, interactions between program staff and users, and special problems which arise in the areas of education, health, nutrition, social services, and parent involvement. Specifically, the report (1) describes the organizational structure and the administrative and support functions of the 6 grantees which run the 43 home base programs: (2) provides profiles of the service delivery systems operating at the home base sites--program design, staff characteristics, resource inputs and service outputs of each program component: (3) provides profiles of the children and families using home base programs--demographic characteristics, mobility, previous exposure to Head Start programs, use of other social service programs, contacts and interactions with current programs; and (4) develops measures of special needs of program users and program efforts to meet these needs. (CM)

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PRELIMINARY REPORT ON HOME BASE FINDINGS

"An Evaluation of Migrant Head Start Programs"

Contract No. HEW 105-78-1304

January 3, 1980

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RC 012282

This report is the first prepared for a contract entitled "An Evaluation of Migrant Head Start Programs" with the Administration for Children, Youth and Families (ACYF) at the Department of Health, Education, and Welfare. The contents of this report do not necessarily reflect the official view of ACYF, but rather the research and analysis performed by J. A. Reyes Associates, Inc.

The Project Director for the contract is David Vesty. Research on various phases of the study was performed by Douglas Anderson, Shelton Cannon, Carlos Cauthen, Herman Farrer, Juan Flores, Sergio Jaimez, Kevin Janet, Stan Jorgensen, Jill Perrott, Renee Trent, and Ralph Walker.

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From the Administration for Children, Youth, and Families, we wish to recognize the continued effort and guidance from Ms. Barbara Bates, Project Officer. Also to be thanked for their assistance are Mr. Dennis Deloria, Chief, Evaluation Branch, Research, Demonstration, and Evaluation Division; Mr. Hank Aguirre, Director, Indian and Migrant Program Division; and Ms. Sylvia Spencer, Community Representative-Liaison, Indian and Migrant Program Division.

We are also indebted to the Advisory Panel of experts assembled for this study: Dr. Mary Beaubien, Chair, Home Economics Department, Youngstown State University; Mr. Joseph de Leon, De Leon and Associates, San Antonio, Texas; Dr. Rumaldo Juarez, Professor, Department of Sociology, University of Arizona; Mr. David Ojeda, Executive Director, Community Services Agency of Dimmit, LaSalle, and Frio Counties (Texas); Ms. Cassandra Stockburger, Executive Director, National Organization for Migrant Children, Inc.; and Sister Blanca Rosa Rodriguez, Assistant Research Scientist, American Institutes for Research.

During the site visits, we met with staff at the grantee level who provided us with invaluable insights into the operation of their Migrant Head Start centers. We wish to express our gratitude to these people for their assistance: Mr. Jerry Santillan, Head Start Director, Campesinos Unidos, Inc.; Sister Geraldine O'Brien, Head Start Director, East Coast Migrant Head Start Project; Ms. Shirley Walker, Head Start Director, Florida Farmworkers Council; Ms. Nancy Hagg, Head Start

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Director, Migrant Opportunities, Inc.; Ms. Elizabeth Sandefur, Head Start Director, Southwest Georgia Community Action Council; and Mr. John Gonzales, Head Start Director, and Mr. Romeo Cinfuentes, Assistant Head Start Director, Texas Migrant Council.

Finally, and most importantly, we thank the staffs at the Migrant Head Start centers for their time, interest, and participation in the study effort. We received their assistance during the evening hours and sometimes on weekends so that our deadlines could be met.

Each of the individuals and organizations mentioned above did and will continue to play a part in the successful completion of this project. Their ideas and experiences in the field of preschool education for migrant children have helped to shape the information presented in this report.

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I. INTRODUCTION

The Head Start programs described in this report serve a special population: children of itinerant farmworker families with incomes placing them at or below the poverty level. It is estimated that migrant farmworkers and their dependents constitute more than a million and a half members of our society.[1] By all accounts, this is a young population; 210,000 are believed to be under six years of age.[2]

While there is little evidence to suggest that the total number of migrants has changed significantly in recent years, there have been two important changes in the composition of this population over the past two decades. The number of migrants who travel without dependents in organized work crews has declined. These migrant laborers are being replaced by migrants traveling as family units in private cars, vans, and pickups.[3] As a result, there has been an increase in the number of very young children exposed to the stresses and contingencies of migrant life.

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[1] An Estimate of the Number of Migrant and Seasonal Farmworkers in the United States and the Commonwealth of Puerto Rico, Legal Services Corporation, 1977, p. 59. The exact figure arrived at in this statistical study was 1,558,176. LSC defines migrants as persons who relocate in order to find agriculture-related employment and includes the dependents of those individuals in their estimate. The relocation requirement distinguishes migrants from seasonal farmworkers who are not forced to relocate or establish temporary residences near their work. The LSC study estimated that seasonal farmworkers and their dependents number 3,444,699.

[2] These estimates were used by ACYF in 1978.

A second major change has accompanied the displacement of the all-male work crew as a traveling and working unit by the nuclear and extended family. The number of Hispanos, and Chicanos in particular, has increased relative to the numbers of blacks and other ethnic groups in the itinerant farmworker population over the past two decades.[4] Today, Chicanos make up more than half -- and possibly three fourths -- of the migrant population.

A. THE ORIGIN AND DESIGN OF MIGRANT HEAD START PROGRAMS

The emergence in the past decade of Head Start programs modified to serve migrant children and families resulted from a recognition of the special needs of migrant children and families. The first

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[3] In a recent field research study for the Department of Transporation, our firm found that the migrant work crew carried from place to place in large trucks and buses has virtually disappeared outside of the East Coast stream, and only 25 percent of the work force travel as work crews on the East Coast. In contrast, 86 percent of the migrant population observed in 32 selected points in the three major migrant streams traveled in their own vehicles. Nearly all of these people traveled in family units. See A Study of the Applicability of Part 398 of the Federal Motor Carrier Safety Regulations to the Inter-State Transportation of Migrant Farmworkers, J. A. Reyes Associates, Inc., 1978, pp. iii-iv.

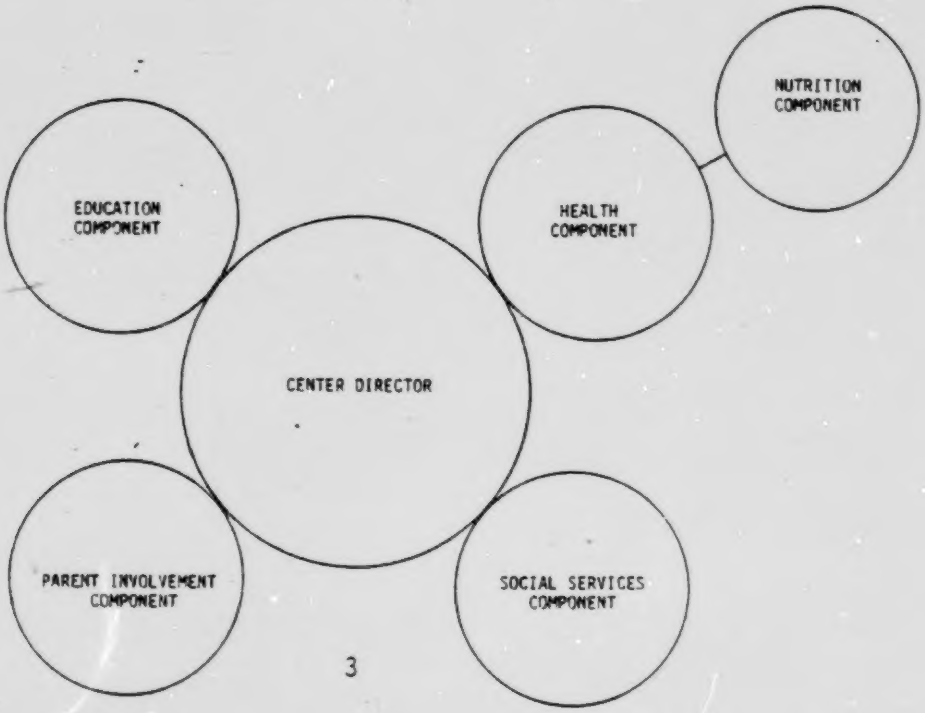
[4] A recent migrant transportation study by J. A. Reyes Associates, Inc., suggests that this change is related, in part, to the shift toward family working units among migrants. Mexican-American migrants showed a marked preference for traveling in family units while the all-male work crews still found in the eastern stream were composed of black laborers. See Ibid., pp. IV-24, 48, 66.

Migrant Head Start (MHS) centers were funded in 1969 through DHEW's newly formed Indian and Migrant Program Division (IMPD). The decision to fund programs consciously modified to serve migrant children under six years of age was based on the assumption that while the migrant child and his family have many of the same pressing needs shared by poor families everywhere, at the same time, they also have special needs which distinguish them from the target population of regular Head Start programs.

The preschool programs funded by IMPD, like regular Head Start programs initiated four years earlier, were (and continue to be) organized around five service areas. As illustrated in Figure 1, Head Start programs have a center director and five major functional components.

FIGURE 1

REPRESENTATION OF THE HEAD START SERVICE DELIVERY MODEL


NUTRITION COMPONENT
EDUCATION COMPONENT
HEALTH COMPONENT
CENTER DIRECTOR
PARENT INVOLVEMENT COMPONENT
SOCIAL SERVICES COMPONENT

Each component requires the use of specialized resources and each has its own objectives and performance criteria. The objectives of these service components, as organized for the purposes of this study, can be stated succinctly as follows:

- Education. To provide a general learning environment and organized classroom activities which stimulate the physical, intellectual, emotional, and social development of preschool children.
- Health. To provide all enrollees with medical and dental care and mental health services, and to educate parents in health-related matters.
- Nutrition. To provide nourishing meals for children participating in programs; to educate parents concerning the nutritional needs of their children and ways of meeting these needs with foods that are available and inexpensive.
- Social Services. To establish an effective outreach program to find and enroll eligible children; to assess the overall health and social service needs of the family; to inform parents about services which are available; and to actively assist them in gaining access to services which they are entitled to use.
- Parental Involvement. To involve parents in program decision-making; to encourage their participation in activities at the learning centers; and to involve them in their child's education in the classroom and at home.

Migrant Head Start and regular Head Start programs are equally committed to these interrelated program objectives. Both programs are expected to meet the standards of performance in each of these five service areas established by the Head Start Program Performance

Standards.[5] Migrant Head Start programs also use the same self-assessment instrument and participate in the same self-assessment/validation process used by regular Head Start programs.

While the migrant preschool programs funded and administered by IMPD have the same organizational elements and performance requirements as regular Head Start, there are also important differences.

- Eligibility criteria. Migrant Head Start programs are to serve only children of poor families who:
  - (1) leave their home temporarily overnight to do hired farmwork in a different county within the same State or in a different State with expectation of eventually returning home, or
  - (2) have no usual place of residence and do hired farmwork in two or more counties during the year.[6]
- Outreach efforts. Because children in this highly mobile population might not otherwise be recruited, programs are to make special efforts to identify children who are eligible and bring them into the centers.
- Health services. Special efforts are to be made to locate and provide medical, dental, mental health, and nutrition services where local resources are scarce.
- Parent Involvement. Programs are expected to develop innovative techniques to involve parents in overall policy-making roles and in program activities.

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[5] OCD-HS Head Start Policy Manual, Chapter N-30-364-4 "Head Start Program Performance Standards," U.S. Department of Health, Education, and Welfare, Office of Human Development Services, Administration for Children, Youth and Families, July 1975.

[6] "IMPD Objectives and Guidelines," Indian and Migrant Program Division, Administration for Children, Youth and Families, Department of Health, Education, and Welfare, 1978. This definition was taken from The Hired Farm Working Force of 1975, Economic Research Service, U.S. Department of Agriculture.

- Other Modifications in Program Administration and Operations. Programs are to be prepared to accommodate fluctuations in enrollment. They are to be prepared to extend their hours to meet the needs of parents who work long hours. They should be able to provide services to all migrant preschool children -- including infants and toddlers -- when there is a need for these services because parents are working. Because the migrant families are by definition itinerant, special efforts must be made to transfer the education and health records of children moving from program to program. Because the first language of a majority of children served at MHS centers is Spanish, most MHS programs must recruit staff and identify learning materials which provide a bilingual learning environment that encourages the development of both English and Spanish language skills. Finally, because migrant families are often unaware of or denied access to public assistance programs, MHS programs are to make special efforts to inform parents of available programs, determine their needs, and actively assist them in using available services.

B. THE EVOLUTION OF THE IMPD MIGRANT HEAD START PROGRAM

Based on an administrative decision made in 1969, the Indian and Migrant Program Division was created in DHEW's Office of Child Development.[7] It assumed certain responsibilities for serving migrants and Indians from the Office of Economic Opportunity.

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[7] The Office of Child Development was replaced by the Administration for Children, Youth and Families.

During the period from 1969 to 1971, IMPD provided approximately $800,000 per year for preschool programs serving migrant children. The funds were distributed through grantees which operated Head Start centers directly or through delegate agencies.

By 1977, IMPD was providing its grantees with $5,857,789 in basic grants and an additional $350,000 for special services for the handicapped. It offered supplementary fundings for grantees in cases where special needs arose during the fiscal year. It encouraged and actively assisted grantees in securing additional funds and in-kind contributions from other local, State, and Federal sources and also provided various forms of technical assistance support for its grantees.

During the 1977-1978 period, the Migrant Head Start budget more than doubled. In Fiscal Year 1978, the discretionary funds allocated by the Secretary of DHEW to IMPD totaled $13,811,379. An additional $744,000 were made available for special services for the handicapped.

In 1979, IMPD is continuing to expand its programs through increased funding for current grantees and the funding of new ones. The objectives of this expansion are: (1) to provide services for more children and families and (2) to improve the quality of services at all program sites.

There are now seven grantees that operate home base programs and 13 grantees that run destination area programs. Two additional grantees sponsor programs operating at both home base and destination areas.[8]

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[8] Home base centers are those which operate from October to May. Programs operating between May and October are classified as destination area centers. They nearly always operate in receiver States rather than at home bases. These figures include new grantees funded by IMPD for FY 1980.

C. THE SCOPE OF THIS REPORT

The Reyes study of Migrant Head Start programs includes all home base and destination area centers using FY 1979 funds provided by IMPD which had operated at the same location during the previous year. New centers were excluded on the grounds that they would be atypical. It was concluded that a study restricted to programs which had operated one or more years would provide a more representative profile of IMPD-funded migrant preschool programs and the children and families they serve.

This report presents the results of Phase I of the field research. During this phase, data were collected at 43 home base sites, and from six IMPD-funded grantees responsible for funding, supporting, and exercising administrative control over programs at these sites. During FY 1979, the six grantees, which operated a total of 47 home base centers funded by IMPD, had a total enrollment of 3,108 children. A listing of the six grantees, the number of programs sponsored by each, and the number of children enrolled at these centers follows.

TABLE 1

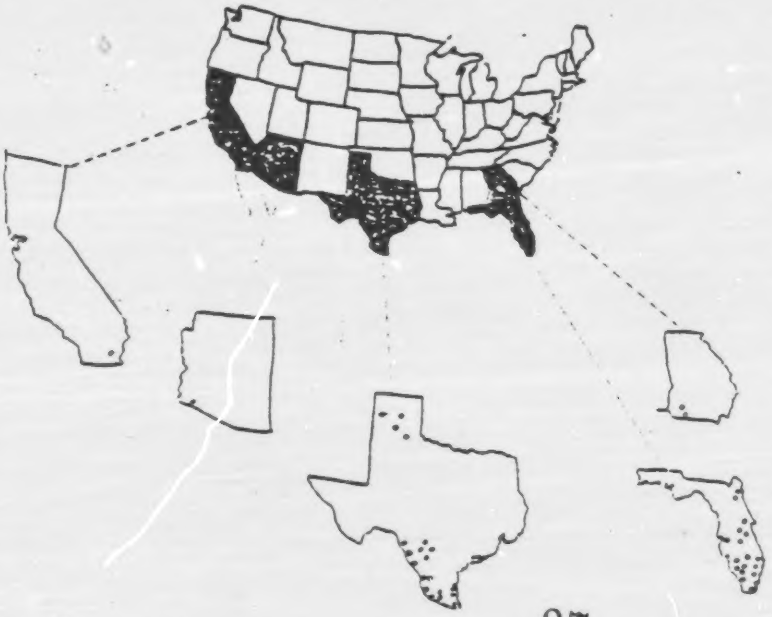
GRANTEES FUNDED BY IMPD WHICH OPERATED MHS HOME BASE PROGRAMS (FY 1979)

Grantee	Total Number of IMPD-Funded Centers	Total IMPD-Funded Enrollment	Number of Centers Surveyed	Enrollment at Centers Surveyed
Texas Migrant Council	20	1,636	20	1,492
Florida Farmworkers Council	14	700	14	589
East Coast Migrant Head Start Project	5	300	5	250
Southwest Georgia Community Action Council	2	85	2	115
Migrant Opportunities, Inc.	3	218	1	110
Campesinos Unidos, Inc.	3	169	1	38
TOTAL	47	3,108	43	2,594

Figure 2 shows the geographical location of the 43 centers.

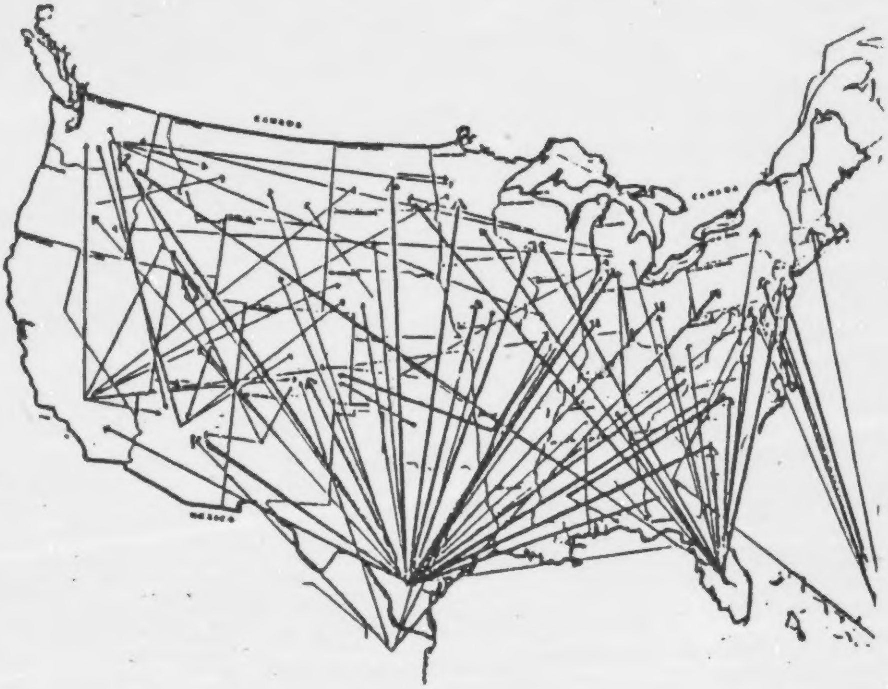
FIGURE 2

LOCATION OF 43 MHS HOME BASE PROGRAMS SURVEYED



Forty of the programs surveyed were located in Florida, Texas, and California, the three major home base States for families entering the migrant stream each year. As indicated in Figure 3, these States are major radiant points of migratory farmworkers who are forced to move from place to place with the change in seasons to find jobs.

FIGURE 3
MIGRANT FARMWORKER TRAVEL PATTERNS



(Source: Report on Farmworkers, Legal Services Corporation, May 1977.)

Two of the remaining three sites were in Georgia, and one was in Arizona. During the winter months, significant numbers of migrant families are found in these States, but the numbers are smaller than those found in Florida, Texas, and California.

These 43 programs all conformed to the basic five-component Head Start model. All were subject to regular Head Start and IMPD guidelines and Performance Standards. Eighteen of these programs were administered by four grantees that run home base programs exclusively. The remaining 25 centers were administered by grantees that operate a service delivery network which includes both home base and destination sites and have programs operating continuously from October to October.

II. PHASE I STUDY OBJECTIVES

The Phase I report on Migrant Head Start (MHS) programs presents data gathered at 43 centers operating between October 1978 and May 1979. The major objectives of this report are:

- To describe the organizational structure and the administrative and support functions of the six grantees which run the 43 home base programs surveyed;
- To profile the service delivery systems operating at the 43 home base sites in terms of program design, staff characteristics, resource inputs and service outputs of each major program component, and other salient characteristics;
- To profile the children and families using home base programs in terms of demographic characteristics, mobility, previous exposure to Head Start programs, use of other social service programs, contacts and interactions with current programs, and other selected characteristics; and
- To develop measures of special needs of program users and program efforts to meet these needs in the areas of:
    - continuity of exposure to MHS and other public service programs,
    - parent involvement in program activities at the centers and in their homes,
    - bilingual, multicultural educational activities, and
    - other modifications of program design and operation required to provide the most effective service possible for the special target population served by MHS programs.

Data have also been collected on service delivery problems perceived by grantee Head Start Directors, center directors, staff responsible for service delivery in each of the five major program components, and parents of children enrolled in programs surveyed. All of these respondents were asked to make any recommendations they believed would help resolve those problems.

While numerous studies of Head Start programs have been completed since 1965, there has been no independent study of the preschool programs for migrant children funded and administered by IMPD. This report -- along with a report on Phase II (destination area) study findings and a report on a comparative analysis of overall findings -- is part of a two-stage review of MHS programs which has been initiated by the Research, Demonstration, and Evaluation Division of ACYF. The Phase I and II reports based on the Reyes study will provide ACYF with (1) a detailed description of home base MHS programs using IMPD funds operating during FY 1979, and (2) a detailed description of the children and families using these programs. The final report will consist of a comparative analysis based on Phase I and Phase II findings. It will identify significant differences among various programs groupings and trace these to their sources whenever possible.

ACYF also views this study as a means of establishing a foundation for a subsequent study of MHS program impacts on the cognitive and affective development of enrollees.

The findings presented in this and subsequent reports are expected to be of value to IMPD program managers. The Phase I report provides them with a comprehensive, detailed picture of home base learning centers operating between October 1978 and May 1979. The Phase II report will provide similar data on programs in receiver

States operating from May to October of 1979. The results are being reported at a time when IMPD is in the process of funding new programs and upgrading the quality of service in existing programs.

The findings are also expected to be of value to specialists in each of the five Head Start component areas who are interested in the welfare and development of migrant children. The report is organized to present detailed, component-specific information on program activities, interactions between program staff and program users, and special problems which arise in the areas of education, health, nutrition, social services, and parent involvement.

III. METHODOLOGY

A. INSTRUMENT DESIGN

1. Sources of Data

The data presented in this report were collected at two levels -- at the central offices of grantees administering home base programs and at sites where these programs operated. At the grantee level, interviews were conducted with the Head Start Directors responsible for the operation of the grantees' Migrant Head Start programs. Written information was also collected during these visits. The purpose of this effort was to secure information describing the grantees' organization and funding sources.

Data were also collected on how programs were modified to meet migrant needs, the nature of the support provided by grantees at the site level, and problems encountered in service delivery. This information provided a framework for the collection and presentation of center level data.

Since the primary focus of this study is at the service delivery level, data detailing the operation of the five-component Head Start Model as it has been modified for the migrant population were collected at all Migrant Head Start home base centers which had been in operation at least one year. All center directors and staff at each site responsible for providing services associated with each program component were interviewed. The center's administration, educational approaches, health and nutrition services, and social services and parent involvement activities were broad topics covered in interviews with the program staff.

A second data source at the center level was the records of children and of program staff. Basic demographic data were recorded from the two sets of records. Detailed health information was collected for the children. Survey teams also recorded a series of observations on the facilities, and the meal time and classroom activities at the centers.

Parents of children enrolled in Migrant Head Start home base programs, selected through a random sampling procedure (see next section), were another source of information. Descriptive data on the family's composition, locations throughout the year, sources of income, and involvement with Migrant Head Start and other child care programs were recorded. Parent perceptions of the care provided for their children at Migrant Head Start programs and parent attitudes toward the programs were also recorded in these interviews. The children of parents sampled who were enrolled in programs were tested, through the use of the English and Spanish versions of the Bilingual Syntax Measure, to determine their proficiency in both languages.

2. Data Collection Instruments

All of the data for this study were collected through instruments specifically designed for the study, with the exception of the language test described in more detail below. These instruments are presented in the Appendices.

A Head Start Program Director Interview was designed to collect information at the grantee level. Again, its purpose was to elicit information on the administration of Migrant Head Start programs from the grantee's perspective.

The Staff Interview Schedule, administered to center level staff, consisted of six modules specifically designed for:

- The person with day-to-day responsibility for the overall administration of the program (i.e., center director);

- The person with day-to-day responsibility for the educational development of the enrollees (i.e., head teacher);
- The person with day-to-day responsibility for providing health services to enrollees (i.e., nurse or health aide);
- The person with day-to-day responsibility for providing nutrition services to enrollees (i.e., cook);
- The person with day-to-day responsibility for linking enrollees and their families with other social services (i.e., social services coordinator); and
- The person with day-to-day responsibility for stimulating the participation of families of enrollees in the center's activities (i.e., parent involvement coordinator).

Data from program and staff records were collected by means of a Topical Guide to Program and Staff Records. A Topical Guide to Children's Records was used to collect information from the records of enrollees. Surveyors recorded general observations of the operations of Migrant Head Start home base centers by use of the Topical Guide for Surveyor's Walk-Through Check List.

Information from the parents of enrollees in Migrant Head Start home base programs was recorded on the Parent Interview Schedule.

a. Pilot Testing

Draft versions of all of the data collection instruments designed for this study were pilot tested at Migrant Head Start home base centers in Florida, Texas, and California during the November 19 to 22, 1978, period. Based on these tests and the review and recommendations of an expert panel, the instruments were finalized.

3. The Bilingual Syntax Measure (BSM)

The selection and application of a testing instrument to measure the language dominance and fluency of a sample of children enrolled in Migrant Head Start home base centers were other tasks of this contract.

The Reyes staff consulted a number of bilingual education specialists and reviewed existing literature on testing for language dominance and fluency. Based on this exploration of alternatives, it was decided that the Bilingual Syntax Measure (BSM) test[9] would best provide the language dominance and proficiency data required to profile and compare Migrant Head Start program enrollees, operations, and program staff. The recommendations of the Director of ACYF's Head Start Strategy for Spanish-Speaking Children, the assessment of bilingual evaluation instruments by Juarez Associates, and their recommendations of the BSM for use in the Head Start Bilingual Bicultural Curriculum Development Project (HEW-105-1048) were central factors in the decision. Considerations leading to the selection of the BSM were:

- The BSM provides quantitative rankings of English and Spanish language proficiency and dominance which can be meaningfully integrated with other data collected on program users and programs and staff characteristics.
- The BSM-English (BSM-E) and BSM-Spanish (BSM-S) versions are both comparatively simple tests that can be administered in 10 to 15 minutes.

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[9] Marina H. Burt, Heidi C. Dulay, and Eduardo Hernandez CH., Bilingual Syntax Measure (New York: Harcourt Brace Jovanovich Inc., 1976).

- While use of the BSM requires that field staff be carefully and thoroughly trained in administering the test and recording and scoring responses, it does not require specialized degrees or knowledge of the theoretical foundations of the instrument.

- Our examination of the test led us to believe the BSM authors succeeded in their efforts to "incorporate the heterogeneity of culturally and linguistically different populations, accept children's perceptions of reality, and avoid the stress-producing characteristics of many testing situations, while at the same time, incorporating the high technical standards required of any measuring device."[10]

a. Pilot Testing

The BSM was pilot tested, along with other elements of the survey instrument package, at Migrant Head Start centers in Florida, Texas. and California during the November 19 to 22, 1978, period.

b. Procedures Established Based on Pilot Test Results

On the basis of the pilot test and the procedures described in the BSM-E and BSM-S manuals and Technical Handbook, a set of procedures which have been followed throughout the course of the study was formalized. These procedures are:

- Both the BSM-E and BSM-S were administered to all Migrant Head Start children in the sample included in the study (see the following subsection) who were three and one half years or older. Since Migrant Head Start programs often serve children in the infant to four-year-old range, a number of children in our random sample of program enrollees fell under the age four minimum suggested for BSM use. Because our pilot test results indicated the test could be administered to children from three and a half to four years of age, thus expanding the number in the sample who could be tested, we decided to include these children in the testing process.

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[10] *Ibid.*, p. 6.

- The tests were administered only by bilingual staff with special training in the use of the BSM-E and BSM-S.
- The BSM-E and BSM-S were administered to each child on successive days whenever possible. Half of the sample at each site received the BSM-E on the first day and half received the BSM-S on the first day. On the second day, each group received the test not administered on the first day.
- A separate room was used for testing purposes whenever possible. A corner of the classroom or playground was used when a separate room could not be found.
- The BSMs were graded by staff after all of the tests for the home base sample of children had been administered. This helped achieve consistency in grading.

B. SAMPLING OF HOME BASE FAMILIES

The sample selection for this study required choices involving three specific data sources -- families to be included for parent interviews, children's records to be reviewed, and children to be tested with the Bilingual Syntax Measure.

1. Sample of Families with Children Enrolled in Home Base Programs

Samples of families with children enrolled in Migrant Head Start home base programs were selected on a grantee-by-grantee basis. The home base centers included in this report were contacted by Reyes approximately two weeks before the field teams visited them. The number of families with children enrolled in the centers at that time was obtained and compiled for each grantee. Simple random samples based on a 95 percent confidence level (± 10 percent), corrected for finite population, were drawn from these figures. Statisticians from the Office of Planning, Research and Evaluation (OPRE) at DHEW recommended using the entire population as the sample for grantees with 50 or fewer families. An additional five percent of each sample was added to the sample size to cover enrollment fluctuations between the time the number of families was collected and the actual date of the site visits.

Table 2 presents the sample sizes for each Migrant Head Start home base grantee.

TABLE 2

SAMPLE SIZES FOR MHS HOME BASE PROGRAM EVALUATION BY GRANTEE

Grantee	Sample Size
Florida Farmworkers Council	84
East Coast Migrant Head Start Project	69
Southwest Georgia Community Action Council	52
Texas Migrant Council	94
Migrant Opportunities, Inc.	48
Campesinos Unidos, Inc.	38
TOTAL	385

The samples were then randomly distributed among the centers operated by the respective grantees. This approach enabled field team personnel to know the number of families that they would be selecting when they visited the centers. (See the next section for the on-site selection procedure.)

2. In-Stream Subsample

A second task of the sampling design associated with the home base study was the drawing of a subsample of families to be traced in-stream during the destination area phase of the study. Those families who indicated during home base interviews that they would be moving during the summer months became the universe from which the in-stream subsample was drawn. Again, simple random sampling based on a 95 percent confidence level (± 10 percent) and corrected for finite population was used to obtain a subsample size of 65 for all grantees.

C. FIELD WORK: PHASE I - SURVEY OF HOME BASE PROGRAMS

1. Presurvey Contact with Grantees

Preliminary steps in preparation for the actual conduct of the home base field work were to notify appropriate IMPD grantee officials of the evaluation and provide them with an overview of the purpose of the survey, the tasks involved in the performance of the survey, and procedures to be used in the conduct of the survey.

In a memorandum dated November 1, 1978, Hank Aguirre, Director of IMPD, informed Head Start Directors of grantees which operate Migrant Head Start programs of the Reyes study. This memorandum outlined specific program elements that would be profiled and the procedures to be used in gathering data. It also served as an official introduction of the company and the evaluation to these grantees.

During the fall and winter months, the Reyes study team had telephone conversations with Head Start Directors and center directors of the IMPD grantees included in both the home base and destination area surveys. These conversations were to provide grantee officials and center directors with further explanation of the study and answer any questions they may have had. The calls were also used to get location information, enrollment figures, and opening and closing dates of Migrant Head Start centers so that sampling procedures could be implemented and a scheduling of site visits could be developed.

In January 1979 the company sent letters requesting further and more detailed information about the grantees and their centers. Attached to these letters were informational sheets to be completed by the grantee, which requested: addresses and telephone numbers of grantees; names of grantee officials; grantee funding levels; names, addresses, and telephone numbers of home base and destination area centers; names of center directors; hours and days of operation of home base and destination area centers; present home base center enrollments; projected destination area center enrollments for 1979; and copies of records formats used at grantee and center levels. This information was requested so that Reyes would be informed about the grantees' operations before any visits to the grantees' offices and so that Reyes could begin to complete its schedule for visits to centers.

On March 15, 1979, at a meeting of IMPD grantees held in Washington, D.C., Reyes staff were given the opportunity to meet representatives from grantees included in the evaluation. At this time, the Reyes staff presented a summary of the purpose and scope of the evaluation and plans for its implementation. The data sources to be explored during the survey and the manner in which data would be collected were also explained at this time. Tentative site visit schedules were distributed to grantees operating home base Migrant Head Start centers. This allowed grantees to alert Reyes to any conflicts or inconveniences site visits could cause at those times, and to notify their centers of the upcoming visits.

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2. Training of Field Teams

On March 17, 1979, Reyes conducted an in-house staff orientation to familiarize those members of the staff who would be conducting field work with proper procedures for visiting a site, interviewing respondents, and examining records. Accounting procedures and requirements were reviewed at this time and methods were established for the training of field team members who would be hired in the field.

On March 25, 1979, the first field team training session was held in Miami, Florida, for the people who would be conducting the home base field work in Florida and Georgia. The second field team training session took place on March 31, 1979, in San Antonio, Texas, for those people who would be surveying in Texas, Arizona, and California. An additional training session for surveyors hired to help conduct the site visit in Arizona was held on May 6, 1979, in Somerton, Arizona.

During these training sessions, the main emphasis was on the data collection instruments and how they should be administered. Training included role playing, with actual use of the instruments.

Two manuals which had been prepared for training, a Supervisor's Manual and an Interviewer's Manual, were distributed, reviewed, and discussed. These manuals were used to educate interviewers and supervisors in the background of the study, administrative information, survey procedures, and interviewing techniques. They also served as a ready reference for supervisors and surveyors during the field work.

3. Site Visit Procedures and Protocol

Before the surveying began, final schedules of visits to grantee offices and home base centers were sent to grantee Head Start Directors for their information and so they could in turn notify their center directors of the dates of visits. The dates of visits were also confirmed by telephone several days in advance.

In accordance with the established protocol, the field supervisor first visited the grantee office and met with the Head Start Director by appointment. The survey procedures were reviewed for the Head Start Director, any questions answered and discussed, and the grantee questions were administered. Then the teams proceeded to Migrant Head Start centers as scheduled to begin the center-level survey.

At the center, the field supervisor first met with the center director to explain the survey, review survey procedures, explain how the data collected were to be kept confidential, and answer any questions the center director had. At this time, a schedule for performing survey tasks was made to assure that team members would not inconvenience the center staff or interfere with the conduct of the center's activities.

Random number tables were used to select families to be interviewed from a list of families supplied by the center director. The center director was asked to notify these families in advance that they would be contacted by the field team. Permission to administer the Bilingual Syntax Measure to children, review the children's records, and proceed with the parent interview was requested from the families, and families were assured that the confidentiality of the information gathered about them and their children would be protected. Also, with the help of center staff, a determination of which language (Spanish or English) the interview should be conducted in was made.

Once a schedule was set, the team proceeded with the survey tasks which included:

- Administering each component of the Staff Interview Schedule (Center Director, Education, Health, Nutrition, Social Services, and Parent Involvement);
- Completing the Surveyor's Walk-Through Check List;
- Reviewing staff records and completing the Topical Guide for Program and Staff Records Review;
- Examining records of children in the sample and recording information on the Topical Guide to Children's Records; and
- Administering the Bilingual Syntax Measure test to children in the sample.

Parent interviews were usually conducted in the evenings since most parents worked during the day. These interviews took place either at the families' homes or at the centers. Sometimes parent meetings had been scheduled at the centers and interviews were scheduled for before or after the meetings.

If the parents interviewed said they would move to find work in the summer, the interviewer gave them a postcard (written in either Spanish or English according to the parent's language preference) and requested that the postcard be sent to Reyes headquarters when the parents arrived at a destination area where they planned to work at least two weeks. This postcard was to aid the Reyes field team in locating parents in the in-stream sample during Phase II of the study.

Also, the interviewer gave each respondent $10 to compensate for the time spent in giving the interview.

4. Schedule of Site Visits

The following table gives the date and location for each site visit completed during the Phase I survey along with the number of parents to be interviewed at the site. Dates of interviews with grantee officials are also included. Usually, two site visits were conducted concurrently. The length of the visits was dependent on the number of families in the sample and the availability of parents to be interviewed. Two to three days were generally required to complete a visit.

TABLE 3

MHS HOME BASE SITE VISIT SCHEDULE

Date	Site Location	Sample Size
FLORIDA FARMWORKERS COUNCIL		
March 26	Meeting with Executive Director, Ft. Lauderdale, FL	
March 26 - 28	Pompano, FL Homestead, FL	4 8
March 27	Interview with Head Start Director, Lake Harbor, FL	
March 28 - 30	Naples, FL (A. Duda)	4
	Naples, FL (Las Villas)	2
April 2 - 4	Immokalee, FL La Belle, FL	5 5
April 4 - 6	Moore Haven, FL Lake Harbor, FL	9 3
April 9 - 10	Pahokee, FL Belle Glade, FL	18 9
April 11 - 12	Okeechobee, FL Indian Town, FL	2 4
April 16 - 18	Ruskin, FL Lake Wales, FL	5 6

(continued on next page)

Date	Site Location	Sample Size
EAST COAST MIGRANT HEAD START PROJECT		
April 18	Meeting with Home Base Coordinator Winter Haven, FL	
April 18 - 20	Winter Haven, FL (Infant & Toddler)	12
	Winter Haven, FL (Preschool)	14
April 24	Meeting with Home Base Coordinator Orlando, FL	
April 23 - 25	Winter Garden	14
April 25 - 27	Hastings	21
	East Palatka	8
May 7	Interview with Head Start Director Washington, D.C.	
SOUTHWEST GEORGIA COMMUNITY ACTION COUNCIL		
April 30	Meeting with Executive Director Interview with Head Start Director Moultrie, GA	
April 30 - May 3	Baconton, GA	20
	Reno, GA	32
TEXAS MIGRANT COUNCIL		
April 2	Interview with Head Start Director Laredo, TX	
April 2 - 4	Laredo, TX	5
	La Grulla, TX	4
April 4 - 6	Mission, TX	4
	Hidalgo, TX	5
April 9 - 10	Alamo, TX	2
	Weslaco, TX	10
April 11 - 12	Edcouch/Elsa, TX	8
	Raymondville, TX	6
April 16 - 18	San Benito, TX	2
	Brownsville, TX	11
April 18 - 20	Cotulla, TX	6
	Carrizo Springs, TX	2

(continued on next page)

Date	Site Location	Sample Size
TEXAS MIGRANT COUNCIL (CONTINUED)		
April 23 - 25	Crystal City, TX	4
	Eagle Pass, TX	6
April 25 - 27	Uvalde, TX	1
	Del Rio, TX	3
April 30 - May 2	Ralls, TX	7
	Lubbock, TX	2
May 2 - 4	Hereford, TX	3
	Plainview, TX	3
MIGRANT OPPORTUNITIES, INC.		
May 5	Interview with Head Start Director Phoenix, AR	
May 7 - 12	Somerton, AR	48
CAMPESINOS UNIDOS, INC.		
May 9	Interview with Head Start Director Brawley, CA	
May 10 - 12	Brawley, CA	38

D. DATA ANALYSIS

1. Preparation of Field Data for Data Processing

When the completed instruments arrived at Reyes' Washington office, they were logged in and re-edited. The instruments were then given to coders who transferred the information from the instruments to IBM coding forms.

Field data were keypunched from the coding forms by Compunetics Corporation, a data entry firm located in Falls Church, Virginia. The machine-readable data were stored on 1600 bpi computer tapes.

2. Data Processing

The data processing for this report was accomplished through DHEW's IBM 370/168 at the Data Management Center (DMC) in Washington, D.C. Programs were submitted by Remote Job Entry (RJE) through an IBM 2741 terminal located in the Reyes offices.

3. Statistical Techniques Used to Describe Program Users and Delivery Systems

Descriptive statistical routines available through Version 8.0 of the Statistical Package for the Social Sciences (SPSS) were employed in this study.

IV. FINDINGS: OPERATION OF HOME BASE SYSTEMS OF PROGRAM DELIVERY

A. GRANTEE ORGANIZATION AND MANAGEMENT

The six grantees operating the 43 home base programs included in the Phase I survey are all private, non-profit organizations. All but one administer several programs directed at migrant children and families, and often at the rural poor in general. These programs are funded at least in part by Federal agencies including the Departments of Agriculture, Labor, and Energy, the Office of Education, and IMPD. The exception is the East Coast Migrant Head Start Project which is devoted exclusively to running the preschool and child centers for migrant children.

All six grantees place overall administrative responsibility for their migrant program in the hands of a Head Start Director. This person reports directly to an Executive Director who oversees all programs administered by the grantee organization. The Head Start Director in turn oversees program administration at the site level.

The following table shows the basic IMPD grants received by each grantee included in the study for FY 1979.

TABLE 4

BASE FUNDING LEVEL (FY 79) TO ORGANIZATIONS OPERATING MHS HOME BASE PROGRAMS

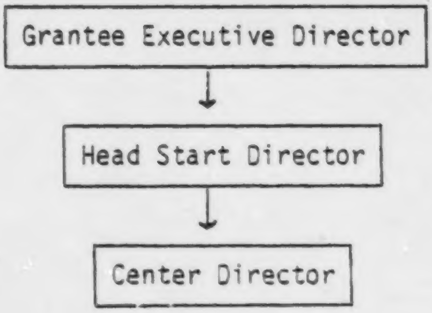
Grantee	Amount of Grant
Texas Migrant Council	$4,016,743*
East Coast Migrant Head Start Project	$2,115,099*
Florida Farmworkers Council	$1,307,024
Campesinos Unidos, Inc.	$ 361,356
Southwest Georgia Community Action Council	$ 167,487
Migrant Opportunities, Inc.	$ 141,872

*Figures for TMC and ECMP include funds used to support home base programs, which operate from October to May, and destination area programs operating from May to October.

The line of administrative authority over the expenditure of IMPD funds in grantee organizations is illustrated in Figure 4.

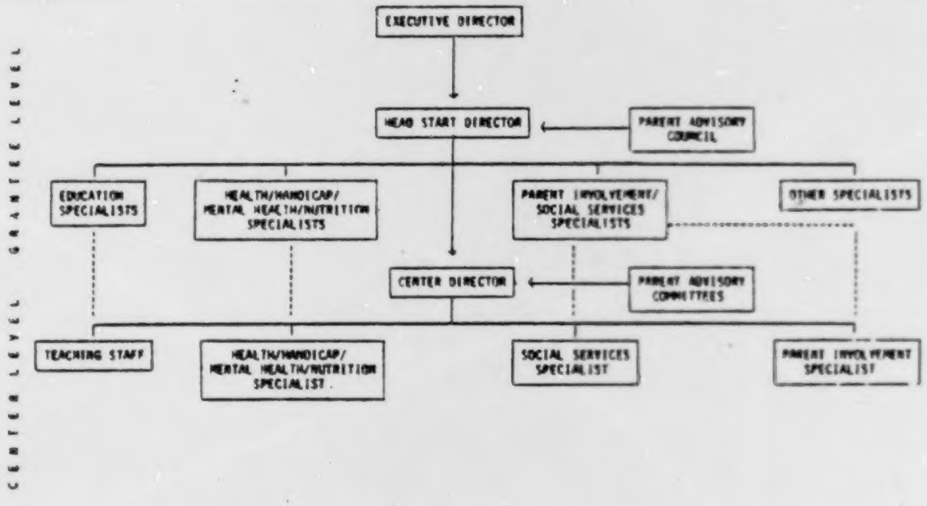
FIGURE 4

LINE OF ADMINISTRATIVE AUTHORITY IN GRANTEE ORGANIZATIONS



Responsibility for developing programs and giving technical supervision to the provision of services in the five major program service areas is shared by specialists on the staffs of Head Start Directors. Center directors at the site level have responsibilities for providing the services. Head Start Directors and center directors also receive input from Parent Advisory Councils and committees established at the grantee and center levels respectively. The following diagram which adds these elements to the skeleton outline presented above illustrates the key elements in program administration and operations at the grantee and center levels.

FIGURE 5
HEAD START ORGANIZATION CHART OF A TYPICAL GRANTEE


GRANTEE LEVEL
CENTER LEVEL
EXECUTIVE DIRECTOR
HEAD START DIRECTOR
PARENT ADVISORY COUNCIL
EDUCATION SPECIALISTS
HEALTH/HANDICAP/ MENTAL HEALTH/NUTRITION SPECIALISTS
PARENT INVOLVEMENT/ SOCIAL SERVICES SPECIALISTS
OTHER SPECIALISTS
CENTER DIRECTOR
PARENT ADVISORY COMMITTEES
TEACHING STAFF
HEALTH/HANDICAP/ MENTAL HEALTH/NUTRITION SPECIALIST
SOCIAL SERVICES SPECIALIST
PARENT INVOLVEMENT SPECIALIST

It should be noted that while this configuration is common to all six grantees, some programs are not large enough or lack sufficient funds to hire individuals with specialized training to work in each of the five major performance areas. This is especially true at the center level where often one person exercises responsibility for service delivery in more than one performance area.

Control over overall policy, administrative procedures, and the allocation of IMPD funds is exercised at the grantee level. Specialists on the Head Start Director's staff generally provide training and technical assistance for their counterparts on the center staff. The grantee Head Start Director is also responsible for conducting the self-assessment evaluations used annually by all Head Start programs to determine whether centers comply with standards established in the Head Start Performance Manual.

While certain organizational elements are shared by all six grantees operating programs included in the survey, there is also great diversity in the organization and operations of grantee programs. These are the result of differences in policy, size, resources, geographical location, characteristics of populations served, and other factors. In the following sections of the report each grantee is discussed individually. Information is based on grant applications, administrative manuals and guidelines issued by grantees, and interviews with grantee Head Start Directors.

1. Texas Migrant Council (TMC)

a. Structure and Organization

TMC is a non-profit organization providing a variety of services to migrant farmworkers. TMC is one of the two home base grantees which also operates child development centers in destination area sites.

Along with East Coast Migrant Head Start Project, it uses a Network Model.[11] TMC provides Head Start services primarily to Mexican-American migrant farmworkers who winter in Texas and spread out during the harvesting season over the Midwest and parts of the West. The 20 TMC home base centers included in this study were serving 1,492 children.

In the Network Model, TMC staff who work at the 20 home base centers in Texas during the winter months load the equipment used at these centers on trucks and travel northward in the late spring, reopening the centers in the western and midwestern States where large numbers of Texas migrants work during the growing and harvesting seasons. Occasionally, a center may be relocated during the summer if crop or weather conditions force migrant families in the area to relocate to find work. Generally, however, a center moves only once during the summer before returning to Texas and reopening there in the fall.

Administration of the home base centers in Texas diverges from the model introduced above in that TMC's program has a third, regional level of administrative authority. Overall programmatic decision-making rests with the Head Start Director who is assisted by both support staff and training and technical assistance advisory staff. Under the Director there are an Assistant Director and three Regional Supervisors. The Three Regional Supervisors have authority over the Valley region, the Panhandle region, and the Wintergarden region, respectively. They receive training and technical assistance from the Regional Advisory Staff. The Migrant Head Start center is the lowest level of administrative authority within TMC. Figure 6 illustrates this organization structure.

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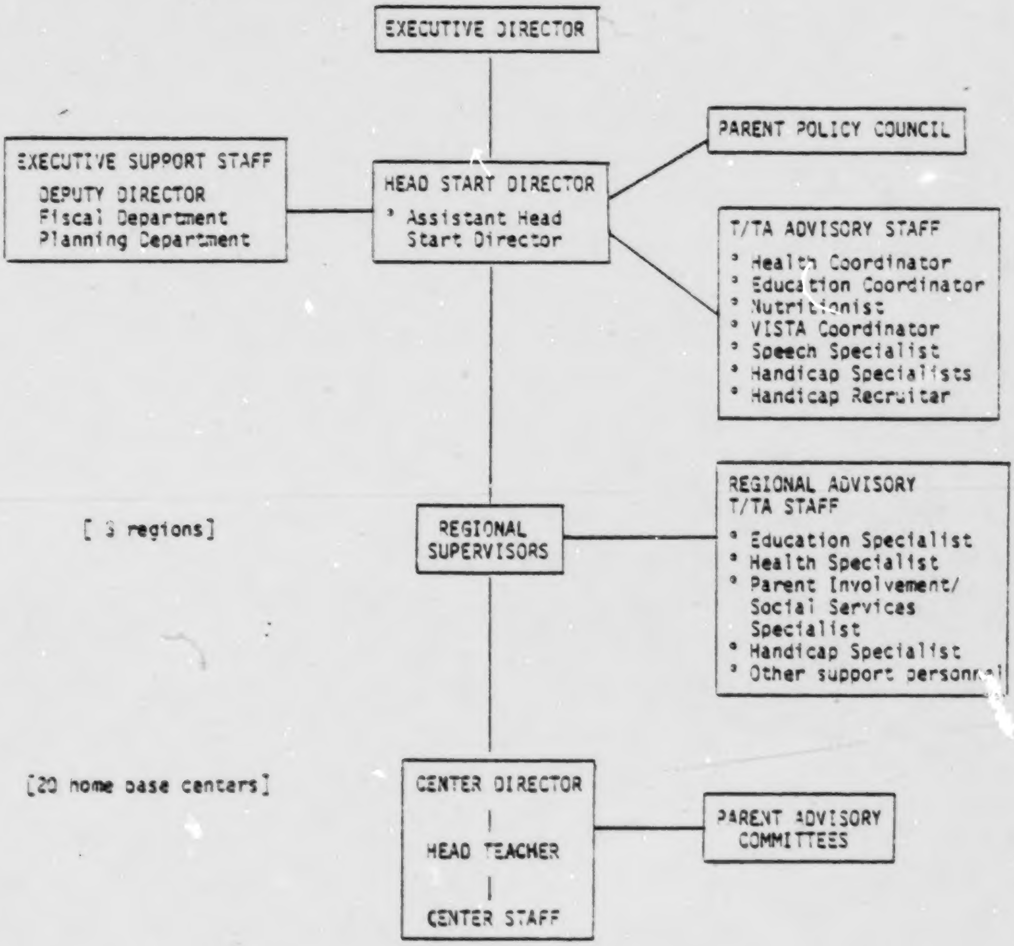
[11] This term describes programs which support a network of centers operating in home base and receiver States, as needed, throughout the year.

FIGURE 6

ORGANIZATION OF TMC'S MIGRANT HEAD START PROGRAM*


EXECUTIVE DIRECTOR
EXECUTIVE SUPPORT STAFF
DEPUTY DIRECTOR
Fiscal Department
Planning Department
HEAD START DIRECTOR
° Assistant Head Start Director
PARENT POLICY COUNCIL
T/TA ADVISORY STAFF
° Health Coordinator
° Education Coordinator
° Nutritionist
° VISTA Coordinator
° Speech Specialist
° Handicap Specialists
° Handicap Recruiter
[3 regions]
REGIONAL SUPERVISORS
REGIONAL ADVISORY T/TA STAFF
° Education Specialist
° Health Specialist
° Parent Involvement/ Social Services Specialist
° Handicap Specialist
° Other support personnel
[20 home base centers]
CENTER DIRECTOR
HEAD TEACHER
CENTER STAFF
PARENT ADVISORY COMMITTEES

*The organization of TMC's other programs differs.

b. Funding - Amounts and Sources

The following budgetary information was provided by TMC on August 20, 1979, by telephone. Note that these data show total funding, rather than dollars spent strictly in support of Migrant Head Start programs.

TABLE 5

TMC BUDGET (FY 79)

Sources	Funds*
Migrant Head Start (IMPD)	$3,934,824
Handicap (IMPD)	195,798
Immunization (IMPD)	35,158
Training and Technical Assistance (IMPD)	30,000
Child and Family Mental Health (Head Start)	39,028
USDA	210,365
Child Abuse & Neglect Prevention Program	259,686
Manpower Program	
Title I	202,379
Title II (ABC-CETA, TX)	37,719
Title II (CETA, TX)	95,594
Title III (CETA, TX)	39,000
Title III (CETA, IL)	26,000
Title VI (CETA, TX)	513,903
Title XX	489,537
Dept. of Justice - Law Enforcement Assistance Administration	215,404
TOTAL	$6,324,395

*These figures include grants for the operation of both home base and destination programs.

Grants from the Indian and Migrant Program Division were used for migrants only. Title XX funds were used in Texas during the summer when there were no migrants in the area to keep some centers open for referrals from the State Department of Human Resources.

c. Basis for Determining Center Locations

The map on page 39 shows the location of TMC's 20 home base Migrant Head Start centers. These sites are selected each year based on enrollment and child recruitment data collected from the previous year. Availability of facilities also figures prominently in the decisions on where to locate centers. Migratory habits and harvest concentrations vary more in destination areas than at home base, where a more consistent pattern is followed.

d. Adaptation to Unique Needs of Migrant Population

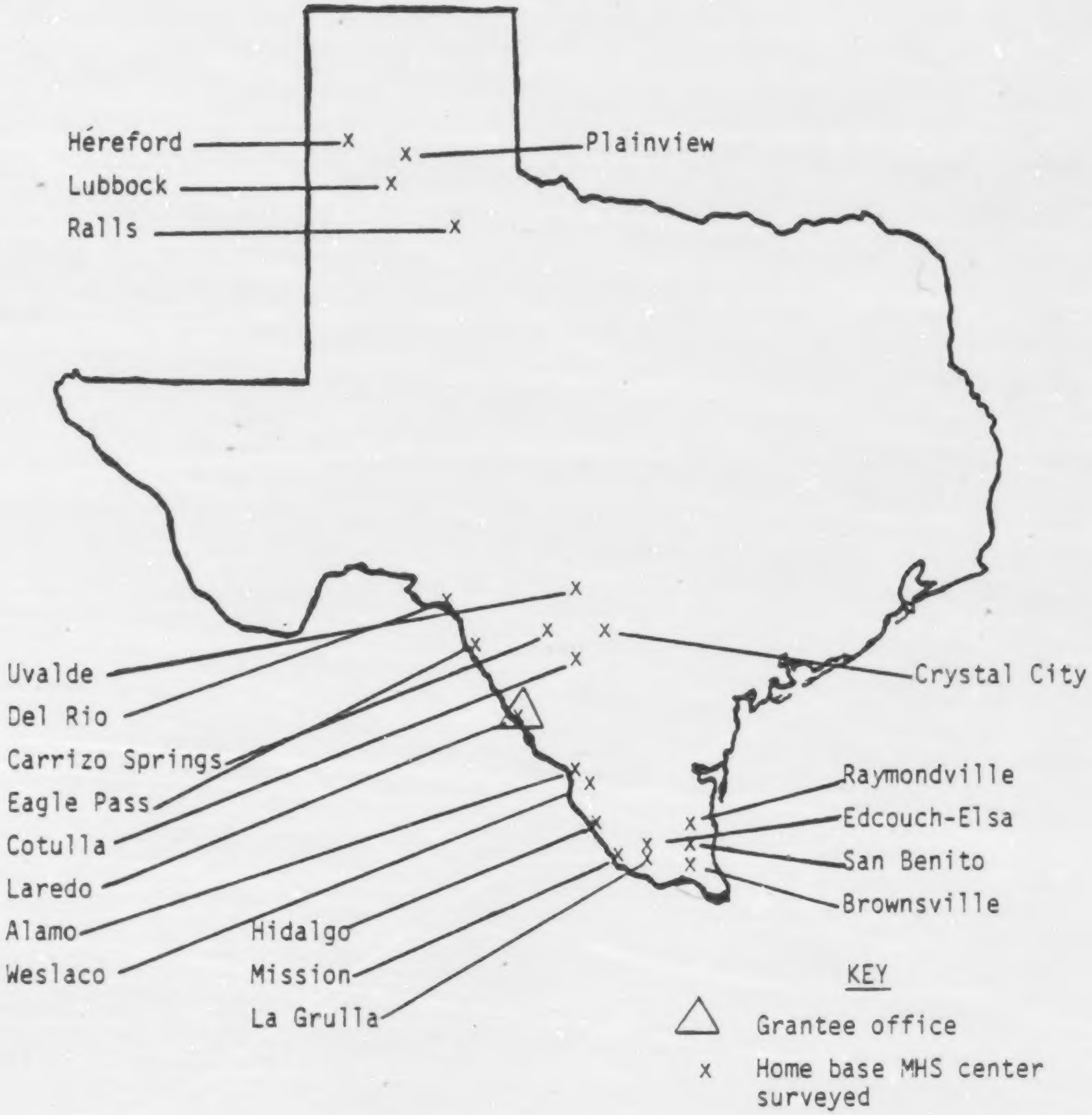
Several questions asked of grantee Head Start Directors focused on how the basic five-component Head Start service delivery system has been modified to accommodate the unique needs of migrants. The observations of the TMC Head Start Director are presented below. They are organized under topical headings which correspond to TMC's perception of the unique needs of the migrant population it serves.

1) Time a Child Is Present

When a family enrolls a migrant child at a center, TMC staff ask each family how long they plan to stay in the area. This information is combined with staff knowledge of agricultural work conditions in the area and is used to develop an individualized service delivery plan for each child during the period that the child is enrolled. Clearly the duration of participation in a program is a more pressing concern in destination area programs. But it is also considered in the provision of services to migrant children enrolled in home base centers.

FIGURE 7

TMC HOME BASE CENTER LOCATIONS


Héreford
Lubbock
Ralls
Plainview
Uvalde
Del Rio
Carrizo Springs
Eagle Pass
Cotulla
Laredo
Alamo
Weslaco
Hidalgo
Mission
La Grulla
Crystal City
Raymondville
Edcouch-Elsa
San Benito
Brownsville
KEY
△ Grantee office
x Home base MHS center surveyed

Although regular Head Start envisions a five-component system with equal amounts of time and energy being devoted to each component, TMC has modified this concept for children who will be enrolled only for a short period of time. For such children, the following services are priorities in the order listed:

- Health,
- Nutrition,
- Education,
- Parental involvement, and
- Social services.

There are obvious overlaps in the Head Start service areas. But the prioritizing of service goals is indicative of TMC's desire to respond to the migrant child's most critical needs first.

2) Extended Hours of Service Delivery

Because of the hours which many migrant parents work, there is a need to extend the hours that Head Start centers are open in order to free parents and older siblings from child care duties. Unfortunately, realization of this goal also necessitates a great deal of overtime work for staff and is currently beyond TMC's staffing budget. However, TMC is attempting to get supplementary Title XX funds which could be used to hire additional staff whose schedules would be staggered over a 12-hour day.

3) Bilingual/Bicultural Differences

TMC hires mainly local, Spanish-speaking staff who have no problem relating to the cultural and ethnic background of the migrant families whom they serve.

4) Parental Involvement

Because of the work schedules of many migrant parents, involving parents in program activities is a major problem for many grantees. TMC has organized a Parent Policy Council (PPC) at the grantee level which administers the parent involvement component at each center. This administrative council has been highly effective and was able to raise sufficient money to build the center which now operates at Eagle Pass.

In addition, a Parent Advisory Committee exists at each center. These are the local arms of the Administrative Policy Council. They make presentations, encourage adult reading and education classes, and organize fund raising activities such as "fiesta nights." They also contribute to an area-wide Parent Involvement Bulletin which is distributed once a month.

The following statement from TMC's grant application summarizes the grantee's approach to the problem of parental involvement.

> Realizing that parents are the first educators of their children, TMC head start has always emphasized the importance of parent involvement. Each year new approaches (not excluding old approaches) are implemented to increase parent participation. Workshops essential in improving parent participation will be provided. Long-term goals include construction of self-sustained and privately owned (corporation) multi-service centers to replace rent-paid facilities presently used by head start centers.
>
> To realize these goals, TMC staff has been working closely with the Parent Advisory Committees to raise funds which we hope to eventually match with other funding sources to construct such facilities. These types of accomplishments make parents self conscious and proud of their efforts and concerns as citizens working to improve their communities.

5) Continuity

The problem of continuity of service is addressed within the TMC organizational structure through its use of the Network Model described earlier. By using the same staff in both home base and destination areas, and through the use of its own central record keeping system, TMC strives to provide continuity of experience for children who leave home base centers and subsequently enroll in TMC destination area sites.

In cases where children from non-TMC centers enter TMC programs, and where TMC children go on to other programs, the continuity problem is more acute. TMC does utilize the Migrant Student Record Transfer System (MSRTS) which provides for exchange of information among grantees. In addition, TMC releases immunization control data by destination area State and sends these data to other grantees within that State. This is not a complete record. It contains only the dates of immunizations received. However, TMC furnishes the complete medical record upon request.

e. Monitoring and Support of Centers

TMC regards preservice and inservice staff training, technical assistance, and other support by grantee specialists or coordinators as key elements in the overall process of monitoring service delivery at a center level. The purpose of this monitoring is to standardize service delivery at a center so that it will conform as closely as possible to Head Start standards and IMPD guidelines.

TMC has a relatively large executive advisory staff including: coordinators in the areas of health, education, and VISTA involvement; specialists for handicapped and for speech development; and a handicap recruiter. There is one supervisor at each of the three TMC regional offices, each with subordinate specialists in the areas of health, education, parent involvement/social services, and the handicapped. TMC also has a nutrition specialist, with an aide, who covers the entire project. This support staff enables TMC to make frequent visits to centers, sometimes as often as three times per week.

Because TMC has a complete staff turnover on an average of once every four years, Head Start orientation sessions are a continuing process. Formalized preservice training is scheduled every August in each of the Head Start component areas. Inservice training is given periodically and focuses on more specific areas. The following workshops and training sessions are examples of inservice training provided to staff in 1978:

- Speech pathology,
- Bilingual curriculum development,
- Child abuse,
- Infant care,
- Behavior modification,
- Dental care.
- Nutrition, and
- Oral language.

In addition to the types of training listed above, TMC encourages its staff to participate in a bilingual/bicultural Child Development Associate (CDA) certification program. Because it is a nationally recognized credential, the CDA certification program is crucial to the success of TMC's Network Model service delivery system. Because of the large number of States in which TMC operates and the variations in State licensing standards, it is important that the TMC staff have professional mobility. CDA certification provides this mobility.

In its grant application, TMC specifically requested $30,000 to continue providing training and technical assistance in the area of child development.

f. Problems and Difficulties

Each grantee was asked to describe the major problems its agency has in providing effective delivery of services to migrant children and their families. The five problems described by TMC are listed below. Where a solution was suggested, it is also included.

1) Mobility

The short length of time that a family spends at one location (especially in destination areas) is a barrier to effective service delivery. TMC suggests that the answer to this problem lies in establishing more centers, i.e.; broadening the "network" of service delivery.

2) Staff Turnover

This is a problem at both the grantee and center level, but the problem is far worse at the local level. In part, the problem stems from the fact that staff are required to relocate to northern States during the summers. TMC suggests two solutions. First, pay the staff more money as an incentive to stay with the program. Second, use a separate staff for destination areas so that home base staff would not have to migrate.

3) Continuity

TMC cited inadequate information referral and feedback both within the TMC network and from other grantees as a major source of discontinuity. It is important to know where a family intends to go *and* to have information concerning the availability of services at that destination. This information is perceived as the key to an effective and efficient referral mechanism.

4) Transportation

Another problem mentioned by TMC was insufficient resources with which to purchase new vehicles. TMC is optimistic that it will be able to secure a grant from the Department of Transportation to add to their fleet.

5) Logistics

The final problem cited by TMC concerned management difficulties experienced because of the long distances between centers. For example, one must travel 600 miles from the grantee office in Laredo to reach the center located in Hereford, Texas. Problems of communication, staff travel, transfer of records, and other administrative difficulties are all aggravated by the large distances between home base centers. TMC could not offer any suggested solution to this problem however.

2. Florida Farmworkers Council (FFC)

a. Structure and Organization

FFC operated 14 home base Migrant Head Start centers located throughout the State of Florida. All of these centers were included in the study.[12] A total of 589 children were enrolled at these centers. The children were predominantly blacks and Chicanos.

As depicted in the organization chart on the following page, the Director of Head Start Programs reports to the FFC Executive Director in Fort Lauderdale, and has Program Coordinators and center staff as subordinates. FFC also operates manpower, vocational counseling, rural development and alcoholism programs, and has a full-time nutritionist on its staff. The Executive Office handles all fiscal and payroll duties and furnishes technical assistance to the Head Start program as needed in these areas.

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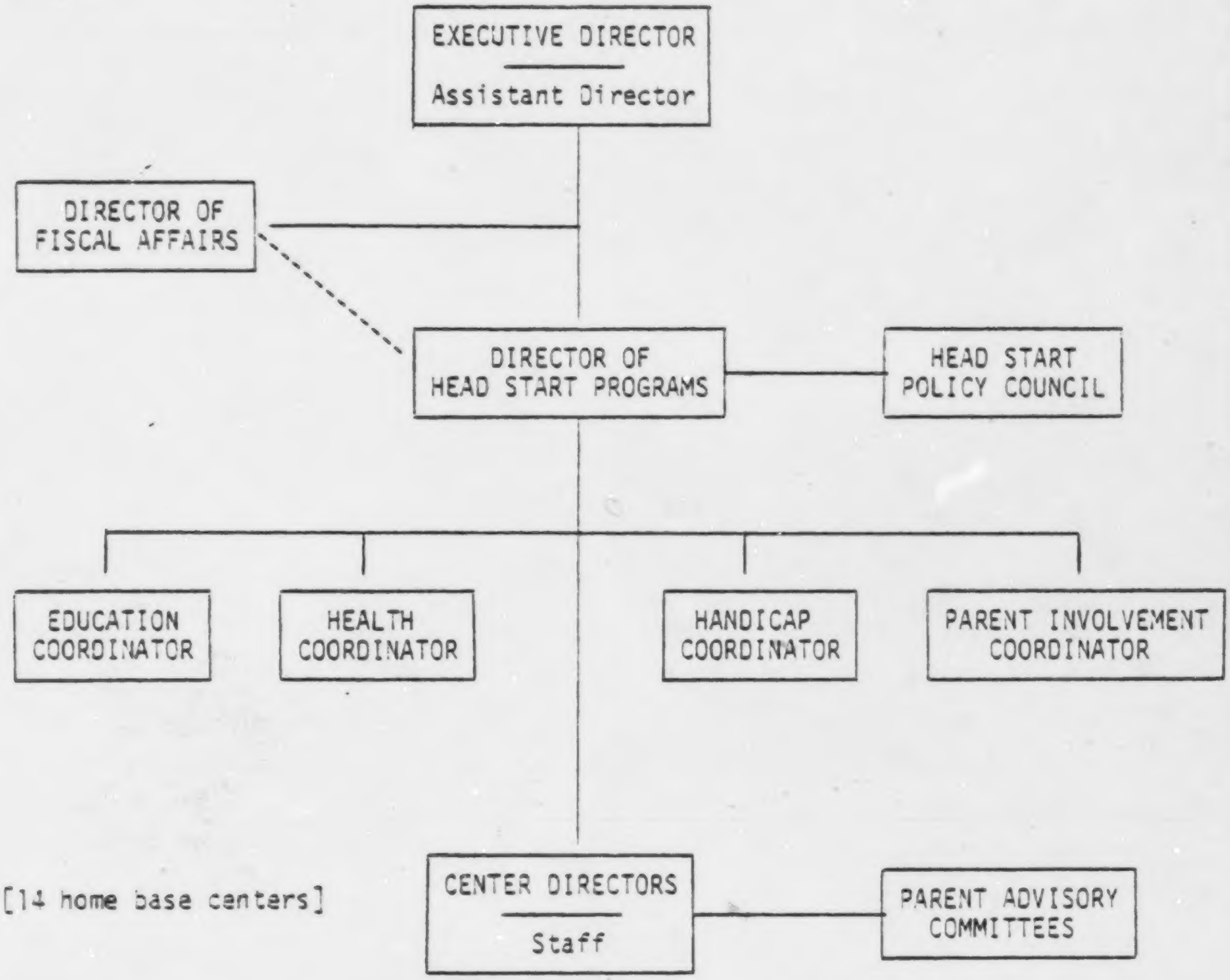
[12] The other center in Wauchula opened during the year but did not enroll any children until September 1979.

FIGURE 8

ORGANIZATION OF FFC'S MIGRANT HEAD START PROGRAM*


EXECUTIVE DIRECTOR
Assistant Director
DIRECTOR OF FISCAL AFFAIRS
DIRECTOR OF HEAD START PROGRAMS
HEAD START POLICY COUNCIL
EDUCATION COORDINATOR
HEALTH COORDINATOR
HANDICAP COORDINATOR
PARENT INVOLVEMENT COORDINATOR
[14 home base centers]
CENTER DIRECTORS
Staff
PARENT ADVISORY COMMITTEES

*This chart does not include the other programs operated by FFC.

b. Funding - Amounts and Sources

The Head Start Director for FFC provided the following budgetary information:

TABLE 6

FFC BUDGET (FY 79)

Sources	Funds
Migrant Head Start (IMPD)	$1,410,303
Title XX	301,365
In-kind contributions (October - March)	6,383
TOTAL	$1,718,051

In addition to the IMPD grant, Title XX funds were expended for migrant children at FFC centers. (See the section on eligibility of enrollees on page 96.)

c. Basis for Determining Center Locations

FFC operates only home base centers within the State of Florida. It is expanding its operations with three more centers in 1979. These three sites are located at Lantana, Indiantown, and Wauchula. Decisions concerning where centers will be located are made on the basis of (1) the needs of the migrant population in an area; (2) the availability of appropriate facilities; and (3) the availability of resources to open a center.

Three sources of information are used by FFC in its decision-making process. The primary source is FFC's many years of experience in dealing with migrant and seasonal farmworkers throughout Florida. FFC has worked exclusively in the area of manpower planning and development and has been able to tap this experience in identifying areas requiring Head Start services.

Another source of information has been the Department of Labor. This information is statistical in nature and is used to identify areas with high concentrations of migrant families.

The final source of information used to determine where Migrant Head Start centers should be located is area residents. FFC often receives reports from concerned community organizations which have noticed migrant children left home, unattended, while their parents are working. When it receives such a report, FFC conducts an assessment of the area and files an area eligibility report with the Board of Directors. If funds are available, the Board may then take steps to establish a Migrant Head Start center in the area.

The location of 16 home base centers operated by FFC in 1979 is illustrated on the map on the next page.

d. Adaptation to Unique Needs of Migrant Population

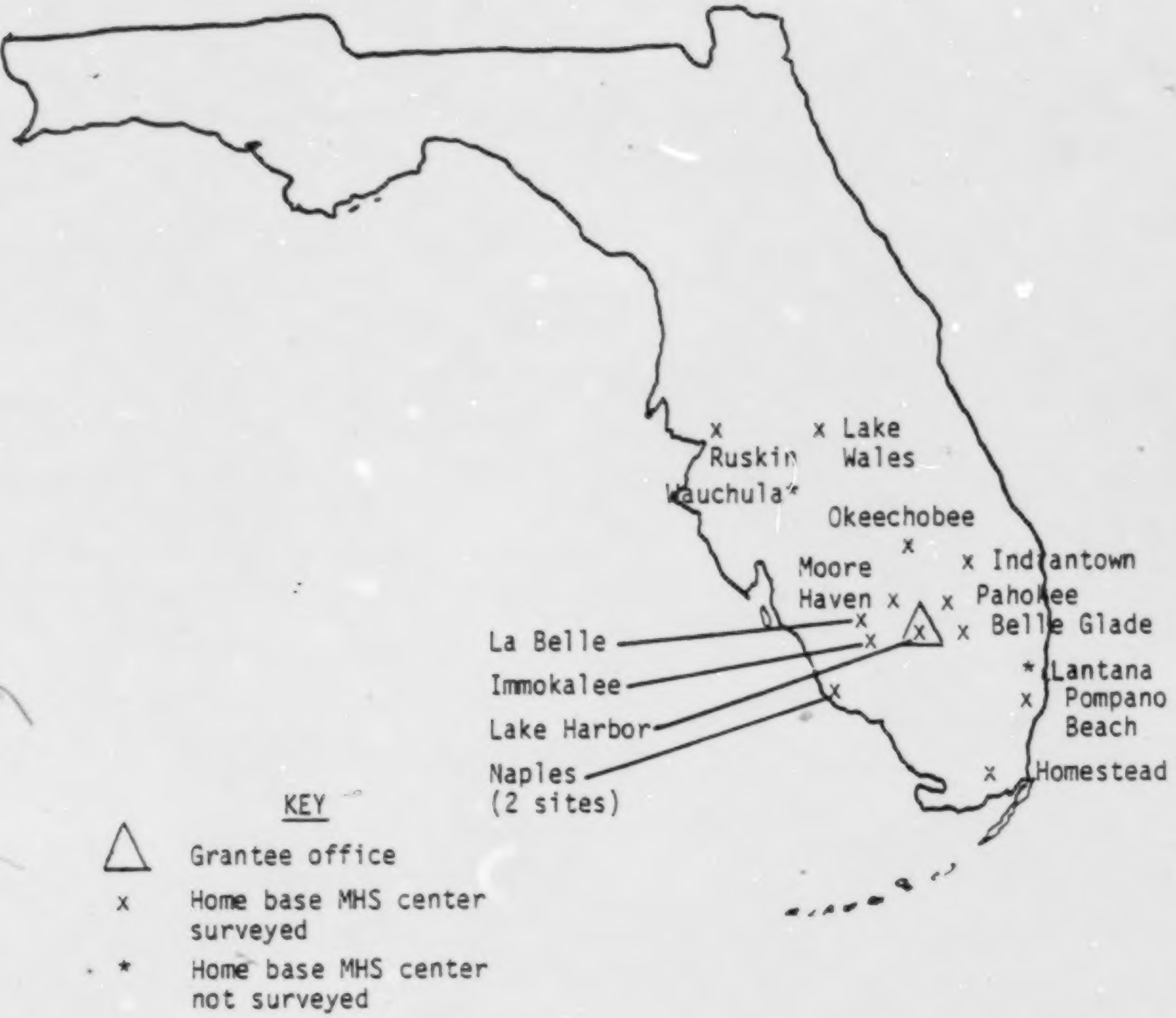
In responding to the question of how FFC has modified its service delivery system to meet the unique needs of migrant children and their families, the Head Start Director was reluctant to admit to any modification. She stated that the program had not been modified because FFC is required to conform to Head Start Performance Standards. Further probing revealed three areas where programs have indeed been adapted by FFC to the unique needs of the migrant culture. These are discussed below.

1) Extended Hours of Service Delivery

FFC has found it necessary to open centers earlier and close them later than regular Head Start programs to accommodate the long working hours of parents.

FIGURE 9

FFC HOME BASE CENTER LOCATIONS


Ruskin
Lake Wales
Wauchula
Okeechobee
Moore Haven
Indiantown
Pahokee
Belle Glade
La Belle
Immokalee
Lake Harbor
Naples (2 sites)
Lantana
Pompano Beach
Homestead
KEY
△ Grantee office
x Home base MHS center surveyed
* Home base MHS center not surveyed

2) Parental Involvement

The same long working hours make it difficult for Migrant Head Start sites to conform to regular Head Start Performance Standards regarding parent involvement.

However, FFC does make strong efforts to secure parent participation in Head Start activities. At the grantee level it has a Head Start Policy Council composed of parent representatives (50 percent) and community persons from the fields of education, social services, and other relevant professions. The Council makes policy decisions which go to the Board of Directors for ratification. At a local level, each center has a Parent Advisory Committee (PAC) which works toward increasing participation of parents in the center's activities.

FFC has developed a Parent Involvement Plan as part of its overall Child Development Program. This plan provides for parent workshops to be conducted at least once per month in areas such as child growth and development, nutrition, education, mental health, and dental hygiene. Parents are also invited to attend staff training sessions. At the center level they receive information concerning their child's development through home visits and conferences conducted at the center. Explanations of teaching methods and assessments which are used by the center are given to parents. Teachers also explain the two principal written curricula used by FFC, Bridge to Reading and South West Lab. Continuing parent education is encouraged through GED and CETA programs and parents receive monthly pamphlets from the University of Florida Extension Service in areas such as consumer education and nutrition.

Note that this is merely a plan and does not measure actual levels of parent involvement within FFC. However, the plan does indicate steps to be taken to encourage parent participation in Head Start activities at the grantee and center levels.

3) Continuity

The periodic movements of families enrolled in Migrant Head Start make it difficult to provide a continuous educational experience for the migrant child. FFC is currently experimenting with some new strategies to help alleviate this problem. The focus of these new strategies is on the parent of the migrant child. They emphasize the importance of informing parents of the value of continuity in their child's educational experience.

While records are generally transferred by FFC centers to other centers, health care providers, and public schools upon request, it is the parent who must seek out new Head Start centers and provide information concerning their child's previous experience with Head Start. In this regard, FFC is emphasizing the importance of children's records at PAC meetings. Beginning next year, parents will be furnished with a continuity record and monthly health summary for their child. In the event that a parent leaves the area without notifying the center, the parent will at least have a copy of the child's basic health and nutrition record. The name of a contact person will also be included on the continuity record in case additional information is needed. By using parents to relay continuity data, FFC hopes to avoid some of the problems it has faced in the past.

e. Monitoring and Support of Centers

Monitoring and support of Migrant Head Start centers is accomplished through several devices. First, FFC holds monthly administrative meetings where problems may be shared on an informal basis. These meetings include center coordinators, program specialists in the areas of early childhood and handicapped education, the health coordinator, the parent involvement coordinator, and specialized consultants in areas such as mental health.

FFC also has a series of Component Plans which are used to guide and assist center staff in planning activities. These plans include:

- An Education Plan,
- A Health Plan,
- A Mental Health Plan,
- A Social Services Plan,
- A Parent Involvement Plan, and
- A Handicapped Services Plan.

The health plan is of special interest because it provides for the formation of a Health and Handicap Advisory Committee which is to meet on a quarterly basis to plan and evaluate the health, handicap, and nutrition components of each of the Migrant Head Start centers.

FFC uses a formal written system for receiving requests for technical support from its Migrant Head Start centers. Under this system, training and technical assistance forms are distributed to all staff. When a center requires T/TA in any area, this form is submitted to the appropriate specialist and a copy is sent to the Head Start Director. Specialists often combine T/TA visits with periodic monitoring visits. These specialists are responsible for providing both preservice and inservice training.[13]

Another device utilized by FFC to monitor and support the delivery of services at its 16 Migrant Head Start centers is a computerized data base centrally maintained at the central office. This data base provides a system which can be used by service coordinators to monitor the activities of each center and the services which it is providing. All center records are fed into this computer. These records then become part of the national MSRTS and can be used by other Migrant Head Start centers that utilize the system.

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[13] The frequency of visits by the handicap specialist is dependent upon the number of handicapped children enrolled at a center.

f. Problems and Difficulties

The FFC Head Start Director interviewed listed major problems which FFC faces in trying to provide effective service delivery to migrant children and their families.

1) Attrition

Because parents depend on the work that is available in a given area, families often move quickly and without notification. FFC staff request all parents to notify the center when they are planning to leave, but parents often do not comply.

2) Continuity

As mentioned above, providing continuity of service between home base centers and destination centers upstream poses a serious problem because of the mobility of families. There is also a problem in coordinating services among the various home base centers operated by FFC and East Coast Migrant Head Start Project within the State of Florida. FFC feels that the solution to this problem lies in the expansion of the MSRTS. Currently, the computerized system is treated as an optional method of records transfer. Consequently, many Migrant Head Start programs do not feed information into the system.

FFC expressed the desire that ACYF require all programs which receive funds to participate in the continuity effort. Funding should be made conditional upon such participation -- either through MSRTS or by sending records with families as they migrate.

3) Head Start Performance Standards

While performance standards offer excellent criteria for operating regular Head Start centers, the Director felt that they are unrealistic for certain areas of Migrant Head Start. The most glaring example is the area of parent involvement. The standards require that each center show documentation of parent involvement and ignore the fact that many migrant parents simply cannot participate because of their work schedules.

FFC suggests that the standards be modified so that in-kind contributions may be counted as parental involvement. Further, if ACYF wants to encourage volunteer work by parents at the centers, it should consider utilizing certain funds to supplement parent income when they take time off from work to participate in training activities. FFC feels that there are many migrant parents who wish to participate and would do so if they could supplement their income sufficiently to take time off from work.

4) Need for More Communication

Because training and technical assistance grants are awarded late in the year, home base projects cannot capitalize on such grants during the summer months when centers are not open. FFC perceives a need for greater communication between Migrant Head Start programs and IMPD regarding training and technical assistance. If FFC were informed of the availability of grants earlier in the year, it could plan its program and activities more effectively.

3. East Coast Migrant Head Start Project (ECMP)

a. Structure and Organization

ECMP is one of two grantees which operate a network of both home base and destination area sites. TMC is the other. ECMP has direct administrative responsibility for its five home base centers in Florida which are included in this study. Three of these sites serve preschool children while the two others provide day care services for infants and toddlers. The five centers serve 250 children, most of whom are Hispanics and blacks.

Through 17 delegate agency organizations, ECMP also provides funding and training and technical assistance support to another 67 destination area centers.[14] These are located in Alabama, South Carolina, North Carolina, Virginia, Maryland, Delaware, New Jersey, New York, and Massachusetts.

ECMP's use of delegate agencies in the eastern seaboard States enables it to run what its Head Start Director has termed a "streamwide" program. By providing funds to programs in destination States, ECMP seeks to use local staff and facilities, while providing these programs with the training and technical assistance necessary to adapt services to summer migrant populations. This has proved to be a cost-effective approach which avoids unnecessary duplication of services. It also builds a cooperative basis in local communities which is used to overcome misconceptions and promote acceptance of migrant families into these communities.

The Head Start Director operates under the jurisdiction of the Executive Director for East Coast's Policy Board, which in turn is under the umbrella of the Leadership Conference of Women Religious. The Director, assisted by a Delegate Agency Specialist, supervises a Home Base Project Coordinator located in Orlando,

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[14] ECMP differs from TMC in its reliance on delegate agency personnel to run center level programs in destination areas. ECMP often provides only partial funding for its delegate agencies, and uses specialists from the grantee level to provide training and support services for these sites.

Florida. This Home Base Coordinator, or Florida Project Coordinator, is assisted by five specialists. These specialists coordinate program activities and support center staffs in the areas of social services, parent involvement, education, health, and handicap services. During the summer months, these specialists provide training and technical assistance support for the 17 delegate agencies. There is also a person with combined delegate agency liaison and nutrition coordinator duties. An organizational chart detailing this structure appears on the next page.

b. Funding - Amounts and Sources

ECMP furnished the following budgetary information for ECMP during an interview conducted on May 7, 1979.

TABLE 7

ECMP BUDGET (FY 79)

Sources	Funds
Migrant Head Start	$2,288,293
Immunization (IMPD)	22,000
Handicap (IMPD)	132,884
TOTAL	$2,443,177*

*This figure includes funding for both home base and destination area centers.

c. Basis for Determining Center Locations

The map on page 58 shows the location of the five home base Migrant Head Start sites operated by ECMP in Florida. The location of destination area sites is a special problem during the summer months when migrant families move up the East Coast. ECMP has attempted

FIGURE 10

ORGANIZATION OF
EAST COAST MIGRANT HEAD START PROJECT
(HOME BASE)

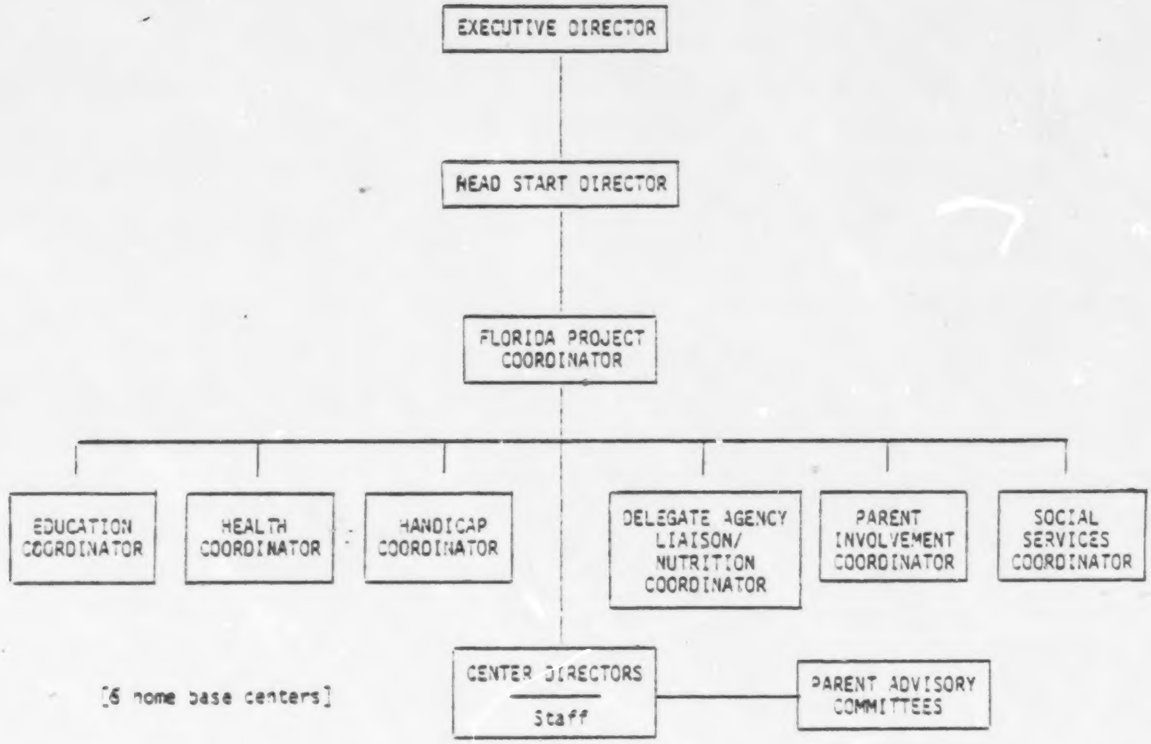
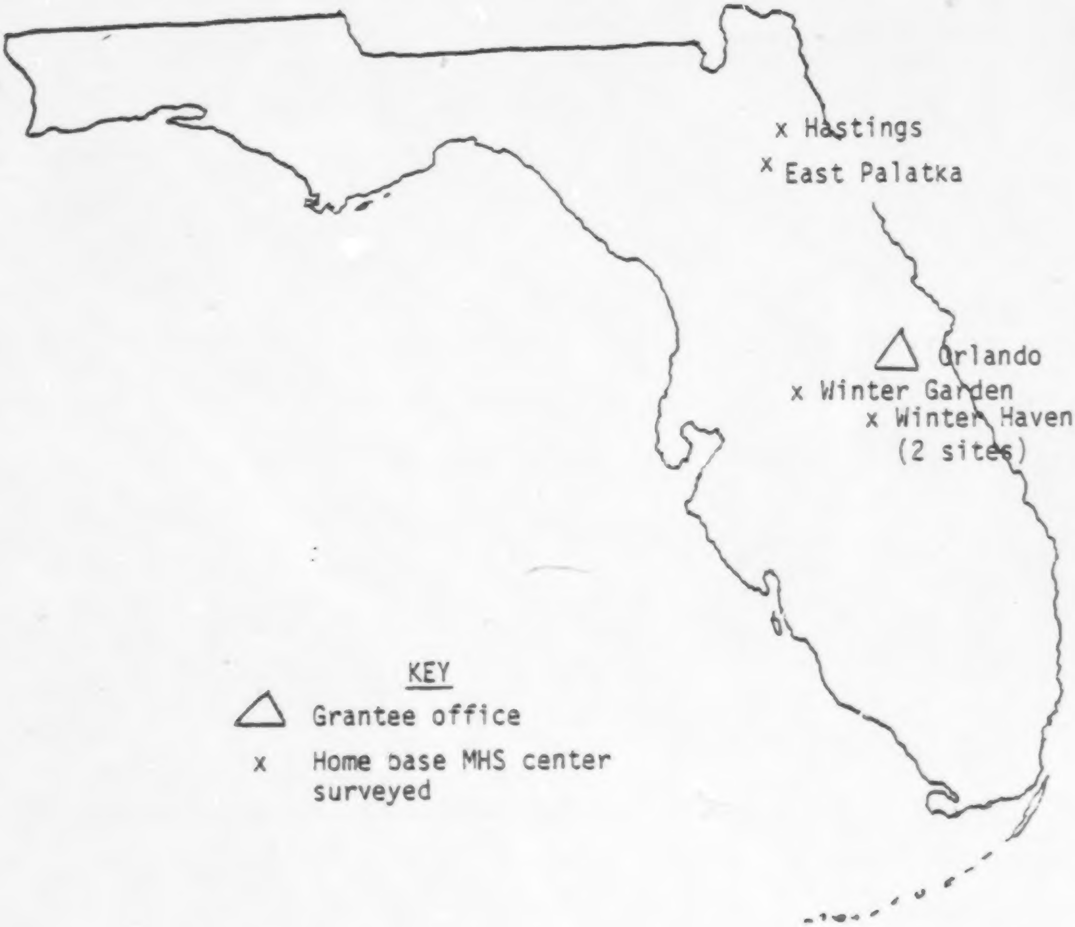

EXECUTIVE DIRECTOR
HEAD START DIRECTOR
FLORIDA PROJECT COORDINATOR
EDUCATION COORDINATOR
HEALTH COORDINATOR
HANDICAP COORDINATOR
DELEGATE AGENCY LIAISON/ NUTRITION COORDINATOR
PARENT INVOLVEMENT COORDINATOR
SOCIAL SERVICES COORDINATOR
CENTER DIRECTORS
Staff
PARENT ADVISORY COMMITTEES
[6 home base centers]

FIGURE 11

ECMP HOME BASE CENTER LOCATIONS


x Hastings
x East Palatka
△ Orlando
x Winter Garden
x Winter Haven (2 sites)
KEY
△ Grantee office
x Home base MHS center surveyed

to set up "tracking sheets" for children enrolled at home base centers. These sheets are maintained in Orlando and show where a child has been within the ECMP system.

ECMP also maintains contact with other migrant education agencies, local farmworker groups, CETA grantees, church groups, health centers, State social service organizations, Head Start, and CAP agencies. These contacts are valuable sources for assessing the need for Migrant Head Start in a particular area. The contacts also serve as a method of coordinating the delivery of services to migrant families.

d. Adaptation to Unique Needs of the Migrant Population

In response to the question concerning how ECMP has modified its service delivery systems, the Head Start Director stated that the basic performance standards are adhered to but programs themselves are adapted in several ways.

1) Infants and Toddlers

ECMP has adapted two of its home base centers to serve infants and toddlers. One of the centers is at Winter Haven and the other is at Hastings. They serve approximately 80 children under the age of three. Providing services to children under three is a specially important adaptation of regular Head Start because, during the work season, the migrant family often has no choice but to take young children to the fields or to leave them in the care of four- or five-year-old siblings. Accepting infants and toddlers into Migrant Head Start programs frees these older siblings from babysitting responsbilities and gives them the opportunity to participate in Head Start. Further, ECMP has found that many of these very young migrant children are in great need of the types of services provided by Head Start because of the rigors of migrant life.

2) Extended Hours of Service

ECMP has extended program hours to more closely match the working hours of parents. The Head Start Director feels that the extended hours improve the overall effectiveness of the programs. In her words, "Longer days provide more time to get things done."

3) Transportation

Because many of the children transported to its centers live in isolated rural areas, ECMP has been forced to use a substantial portion of its budget to purchase, maintain, and insure school buses and vans. While the distance that children must be transported poses problems at home base centers, this problem often becomes even greater at destination area centers along the East Coast.

4) Multiethnic Programs

Migrant Head Start programs are to be adapted so that service delivery relates to the ethnic and cultural backgrounds of the children enrolled. ECMP's Head Start Director noted that adaptations often must go beyond broad ethnic classifications to distinguish among different types of Hispanic children and among Native American children who belong to different tribes.

5) Continuity

Providing continuity in the Head Start experience for the migrant child is a primary concern of ECMP. It has wrestled with the problem for years. The following statement on this issue appeared in the ECMP 1979 Grant Application:

> As a result of the team visit with the Self-Assessment/Validation Instrument in delegate agencies, weaknesses in the concept of continuity became apparent....It was decided, if continuity is truly the goal the project wishes to achieve, some modification in thought was necessary. The concept of homebase and upstream did not necessarily promote continuity but perhaps really created two programs.

In response to the problem, ECMP has initiated several changes. Two new positions were created -- a Delegate Agency Specialist who works out of the executive office in Washington, D.C., and a Delegate Agency Liaison in Orlando. These two persons have primary responsibility for facilitating continuity between home base and destination area programs.

ECMP has also modified its records and record-keeping system to facilitate continuity. An elaborate procedure has been established to ensure the flow of health and developmental records between centers. Under this system, each destination area center is furnished with a master alphabetical list (Health Control Summary) of all children served in Florida. Local recruiters receive preservice training on how to identify children from the list who are enrolled in destination area programs. When a child from a home base center enrolls in a destination area program, the recruiter requests the child's complete records from Orlando. A copy of those records is then mailed to the requesting center. The records are returned to Orlando when the child withdraws from the local program. When the destination area center closes, a list of all children served, including their birth dates and their home base addresses, is sent to the Orlando office.

Finally, ECMP has initiated a procedure for giving each parent a continuity of service record when the child withdraws from a center. Basic information is included in a folder that has a snapshot of the child posted to the cover. This snapshot idea has proven to be valuable because it decreases the likelihood that the parent will lose or discard the record. The folder is called a "goodbye book." It contains the name and location of the center the child is leaving; basic information concerning immunizations, physical examinations, and developmental level; and the address and phone number of the Orlando office where a complete set of records may be obtained.

6) Parent Involvement

Parent involvement is a recurring theme in ECMP job descriptions, plans of action, performance evaluations, and outreach guidelines. In 1979, ECMP has made strong efforts to encourage staff at local centers to actively seek involvement of migrant parents. The following devices have been utilized by center staff with varying degrees of success:

- Notes to parents,
- Home visits,
- Parent meetings,
- Newsletters,
- Use of a Head Start Parent Handbook with parent boards, and
- Center visits with parents.

One outreach device has proven to be especially effective. It involves publicizing Head Start involvement activities through the church. By meshing activities with Sunday Mass, a great many Hispanic parents have been brought into the program.

At the grantee level, there is a parent involvement coordinator who oversees the parent involvement component at all five home base centers. This coordinator has been instrumental in establishing local parent policy groups. These groups have worked with the ECMP Policy Board in completing the Self-Assessment/Validation Instruments for the Florida centers.

e. Monitoring and Support of Centers

Monitoring and support of home base centers is provided in each of the component areas by the home base coordinator for that component. ECMP depends heavily on formal plans of action, one for each specialist coordinator. These plans of action are modified to fit the situations of delegate agencies. There is also a Training and Technical Assistance Plan for pre- and inservice training for each Head Start component. The preservice training is preceded by a preservice needs assessment.

A typical plan, e.g., the plan of action for education, is composed of three parallel columns, one for strategies, one to list the title of the person or persons responsible for each action listed in the first column, and a final column to give a time table for completion. The strategies are detailed and specific, and grouped by objective. The Education Plan lists 54 separate strategies.[15]

Using these plans as a tool, the grantee monitors each delegate agency program halfway through the session, and more often if special situations arise. The home base centers in Florida are visited at least twice a month by each coordinator.

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[15] Similar plans exist for health, medical services, dental services, mental health, handicap, nutrition, parent involvement, and social services.

f. Problems and Difficulties

The Head Start Director from ECMP listed five major problems which ECMP faces in providing services to migrant children and their families.

1) Facilities

It is often difficult for ECMP to obtain facilities for both home base and destination area programs. Fulfilling different State licensing requirements is the primary obstacle. ECMP cited the need for increased Federal funds to pay for building, maintaining, and expanding facilities.

2) Health Services

In many areas comprehensive health services are not available. It requires persistence and dedication by center staff to find good medical and dental care for the migrant children. Further, when quality services are found, they are very expensive. For example, the minimum cost of dental care per child is roughly $75.

3) Transportation

Many of the destination area programs do not have a sufficient number of vehicles to take children to and from centers. To alleviate this situation, ECMP makes some of the vehicles used at home base sites available for use by delegate agency centers.

However, because of the distances many children live from a center, and from one another, and the different times which parents leave for the fields in the morning, some children are subjected to a two- or three-hour bus ride. Unfortunately, the high cost of purchasing and maintaining suitable vehicles makes it impossible for ECMP to add new vehicles and thereby reduce the time spent by children on the road.

4) Bilingual Staff

While not a problem at home base sites, additional bilingual staff were needed in some delegate agency programs. ECMP is working to overcome this problem, but the shortage of qualified applicants in many northern destination States has frustrated their efforts. ECMP utilizes bilingual home base staff in destination centers where they are particularly needed.

5) Community Attitudes

At some locations ECMP staff are hindered in their efforts to help migrant children and families by community resistance. Some people view migrant children as dirty and lice-afflicted, and unsuitable associates for their own children. The ECMP Head Start Director remarked that these attitudes need to be changed through increased community education and understanding.

4. Southwest Georgia Community Action Council (SWGA)

a. Structure and Organization

SWGA operates two migrant and seasonal farmworker child development centers funded by IMPD. These two centers were serving 115 children at the time of the visits. SWGA also operates six other child development centers throughout a seven-county area of Georgia which do not receive Migrant Head Start money. It also runs neighborhood service centers, a senior citizens program, energy and rural housing programs, and an emergency services program.

Most decisions which affect the operation of the centers are made at the central staff office in Moultrie. The central staff is composed of the following personnel: the Director of the Program who coordinates all phases and is responsible for meeting the guidelines designed by DHEW; a Handicap/Medical Services Coordinator, a registered nurse, who arranges for all medical, dental, and mental health care as well as clinics for diagnosis and treatment for children with special needs; a Social Services/Parent Involvement Coordinator who serves as a resource person for parents, arranges parent workshops, and encourages parent and community support; an Education Coordinator who develops and assists teachers in the implementation of the curriculum used in 31 classrooms; and a Nutritionist who prepares nutritionally balanced menus and orders the food.

An organizational chart showing the elements of SWGA directly involved in administering IMPD funds appears on the following page.

b. Funding - Amounts and Sources

The Program Director for SWGA provided the following budgetary information for the Council. Note that this total funding figure covers all eight centers operated by SWGA, not just the two IMPD-funded centers included in the survey.

TABLE 8

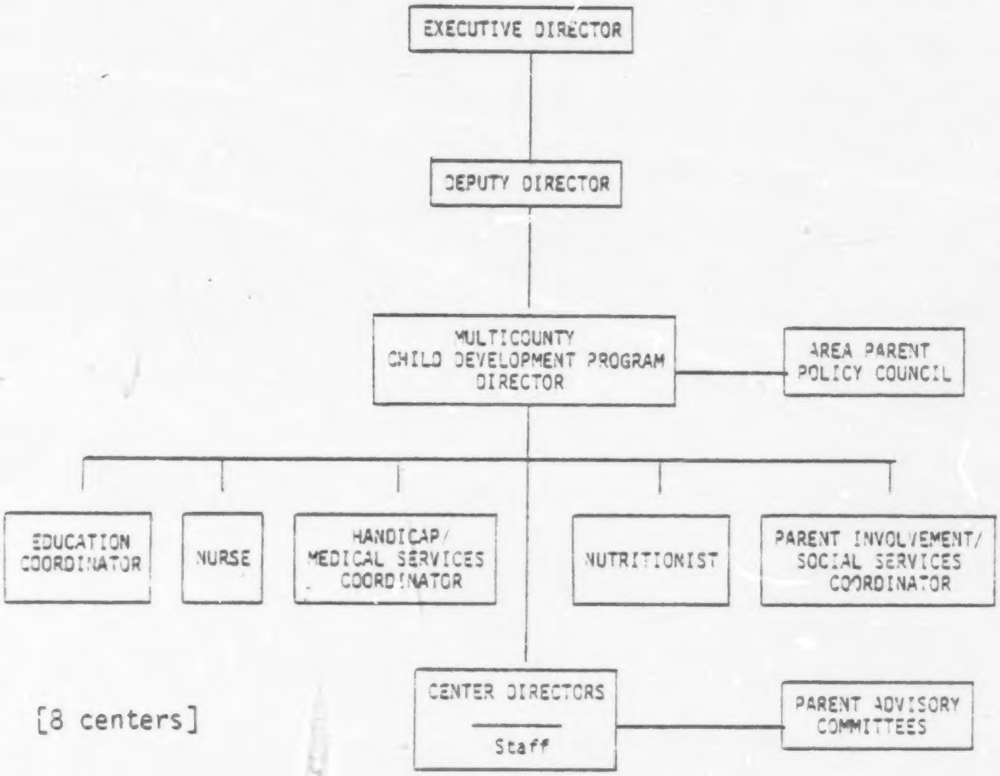
SWGA BUDGET (FY 79)

Sources	Funds
Head Start	$ 730,575
Migrant Head Start (5/1/79-4/30/80)	181,019
Handicap (IMPD) (5/1/79-4/30/80)	45,255
Title XX	17,160
In-kind contributions	216,085
TOTAL	$1,190,094

Some regular Head Start funds were expended in the two centers with IMPD-funded children. All children funded by Title XX were in the other six child development centers.

FIGURE 12

ORGANIZATION OF SWGA'S HEAD START PROGRAM
(INCLUDING MIGRANT HEAD START PROGRAMS)*


EXECUTIVE DIRECTOR
DEPUTY DIRECTOR
MULTICOUNTY CHILD DEVELOPMENT PROGRAM DIRECTOR
AREA PARENT POLICY COUNCIL
EDUCATION COORDINATOR
NURSE
HANDICAP/ MEDICAL SERVICES COORDINATOR
NUTRITIONIST
PARENT INVOLVEMENT/ SOCIAL SERVICES COORDINATOR
[8 centers]
CENTER DIRECTORS
Staff
PARENT ADVISORY COMMITTEES

*This chart depicts only part of the service delivery components operated by SWGA.

c. Basis for Determining Center Location

Several factors are considered by SWGA in determining the location of child development centers. First, because SWGA has operated a community action program since 1965 and has worked extensively with migrant and seasonal farmworkers during the last 14 years, it is familiar with the agricultural working conditions throughout the State. This knowledge is used to locate centers where there are large concentrations of seasonal farmworkers and migrants, and consequently a need for Migrant Head Start programs.

A second consideration is the availability of suitable facilities which are centrally located for the user families in the area. SWGA looks for buildings which may be renovated so that they are suitable for Head Start children and meet State licensing requirements.

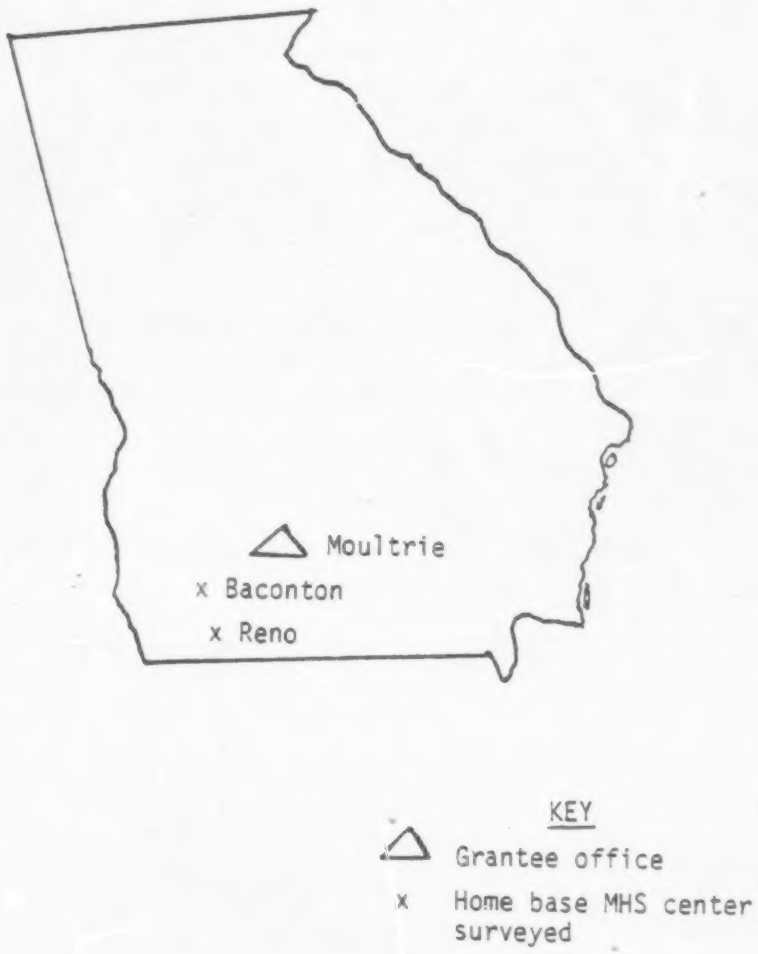
A third consideration mentioned by SWGA is the need to locate a site close enough to the families it will serve so that children may sleep at home each night.

The map on the following page shows the location of the two Migrant Head Start sites which Reyes visited in May 1979.

d. Adaptation to Unique Needs of the Migrant Population

Most of the families served at the Migrant Head Start sites in Reno and Baconton are black, English-speaking seasonal farmworkers who do not migrate out of State. Therefore, many of the bilingual/multicultural adaptations required at Head Start centers serving more geographically mobile Hispanic families are unnecessary at the SWGA centers. SWGA, however, stated that it does maintain a close watch on the intrastate movement of the seasonal farmworker population and on the availability of local community resources. This enables it to accommodate fluctuations in enrollment easily and efficiently and helps it plan service objectives for the future.

FIGURE 13
SWGA HOME BASE CENTER LOCATIONS


△ Moultrie
x Baconton
x Reno
KEY
△ Grantee office
x Home base MHS center surveyed

1) Extended Hours of Service Delivery

Centers begin operations at 7:30 in the morning and do not close until 4:00 or 5:00 in the afternoon. These hours have been tailored to the working hours of most parents.

2) Parent Involvement

To encourage parent involvement, open houses are held at the centers and there is a meeting of parents at least once per month. Such meetings are scheduled at night so that parents may attend. Raffles have been held to raise money for the purchase of materials and equipment for the centers. There are sewing machines available at the centers and earlier this year parents came into the Reno center to make blankets and quilts which were raffled as prizes. Cribs are also available at the centers so that parents may bring infants when they come to participate in center activities.

According to the Head Start Director, parents from both Migrant Head Start centers serve on the Parent Policy Council. This council elects parents to attend both the State Head Start conference and the National Conference.

Another method of encouraging parent involvement is a Handbook for Parents which was prepared by SWGA and is given to parents when their child first enrolls at a center. The Handbook explains the operation of Head Start with particular emphasis given to the parent involvement component. In addition to meetings and literature given to parents, the centers at Baconton and Reno utilize the local Baconton newspaper to publicize events in which parents may participate.

3) Continuity

Most of the families of children enrolled are seasonal farmworkers and do not migrate out of State so there is very little transferring of records between different programs and/or different grantees.

Last year SWGA began using an adaptation of the ECMP "Good-Bye Book" as a means of transferring information and records from its preschool program to the public school system. When SWGA is contacted by the public school system requesting records, parental consent is first obtained, and then the child's records are transferred to the public school.

e. Monitoring and Support of Centers

SWGA monitors service delivery very closely at each of the child development centers which it administers. There is frequent contact by phone as well as a written monthly report which must be filed by each center. There are visits at least twice a month by grantee specialists in one of the five Head Start component areas. These visits are sometimes conducted without notice. If a center is experiencing difficulties or if the monthly report indicates problem areas, then visits may be conducted more frequently.

SWGA has established an Objectives and Operating Plan which encompasses each of the five Head Start component areas. For each component, overall objectives have been established and specific milestones have been identified. A timetable has also been established for accomplishing each of the milestones listed in the Plan. The Plan includes the provision of preservice and inservice training by component to center level staff.

f. Problems and Difficulties

The SWGA Head Start Director identified four major problem areas in delivering effective services to Migrant Head Start families.

1) Assessments

SWGA felt that the assessment methodology utilized by IMPD to validate Migrant Head Start programs is inadequate. It stated that the assessment process needs to be modified to more accurately reflect the cultural differences of the migrant user population.

2) Cost of Medical Services

Another problem faced by SWGA is the high cost of medical care and dental services in the areas in which programs operate. It is especially hard to find qualified doctors and dentists who are willing to help the program.

3) Transportation

Like several other grantees, SWGA cited a lack of adequate numbers of buses and vans to transport the children. Because of the poor condition of many of the rural roads which are used, maintenance costs are high. It was suggested that additional Federal money should be made available to purchase new buses and vans.

4) Licensing Standards

Licensing standards are controlled in Georgia by the Department of Human Resources and vary from county to county. In addition to these county-level variations, the licensing standards for preschool facilities are more rigorous than for those for school-aged children. These variations result in operational inconsistencies from center to center. SWGA also incurs additional expenses in modifying existing facilities to meet the more exacting preschool licensing standards.

5. Migrant Opportunities, Inc. (MOP)

a. Structure and Organization

Migrant Opportunities, Inc. (MOP), operated three IMPD-funded home base centers during FY 1979 in Arizona. Two centers were located in Pinal and Maricopa and not included in the study. At the time of the visit, the third, located in Somerton, served 110 preschool children, all of whom were Mexican-American. MOP had temporarily assumed responsibility for the Somerton program during the 1978-1979 program year. It had previously been funded by IMPD grants channeled through another Arizona grantee, SER-Yuma.

MOP is an independent migrant farmworkers' organization which runs a diverse set of programs supported by various Federal agencies including the Department of Energy and the Department of Agriculture. The chart on the following page includes only the segment of the agency involved directly in the management and support of the Somerton program.

The MOP Executive Director and Head Start Coordinator[16] have offices in Phoenix, where the organization is headquartered. The Head Start Coordinator had no staff specialists assisting her to monitor and support staff responsible for the site level program. Three specialist slots existed -- Education Coordinator, Parent Involvement/Social Services Coordinator, and Health/Handicap Coordinator. These positions had not been filled as of May 4, 1979, when the survey was conducted.

b. Funding - Amounts and Sources

Migrant Opportunities received a $443,459 grant from IMPD for Fiscal Year 1979. It received $4,236 from USDA's Child Care Food Program and another $2,502 from Senior Citizens. This brings total FY 79 funding to $450,147.

The MOP Head Start Coordinator added that in the near future the agency intends to apply for a Title I Migrant Education grant and hopes to secure additional funds under the Title VII Bilingual Education program. Some in-kind contributions were used in support of the Migrant Head Start program, but these had not been itemized.

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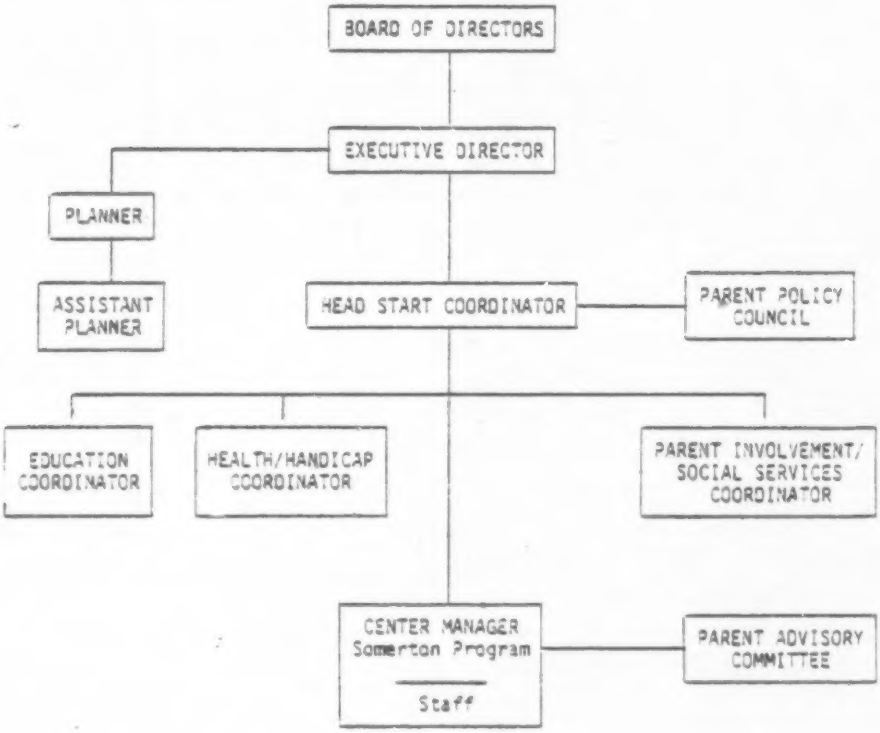
[16] This staff position is equivalent to the Head Start Director position on other grantee staffs.

FIGURE 14

ORGANIZATION OF MOP'S MIGRANT HEAD START PROGRAM*


BOARD OF DIRECTORS
EXECUTIVE DIRECTOR
PLANNER
ASSISTANT PLANNER
HEAD START COORDINATOR
PARENT POLICY COUNCIL
EDUCATION COORDINATOR
HEALTH/HANDICAP COORDINATOR
PARENT INVOLVEMENT/ SOCIAL SERVICES COORDINATOR
CENTER MANAGER Somerton Program
Staff
PARENT ADVISORY COMMITTEE

*This chart depicts only part of the service delivery components operated by MOP.

c. Basis for Determining Center Locations

In determining the location of its Head Start centers, MOP makes use of information in State Department of Agriculture publications on planting and harvesting schedules and migrant worker movement. Local boards consisting of migrant workers are also asked to make suggestions and indicate which areas should be given priority. Outreach workers are another source of information on the numbers and movement of program users. The availability of facilities and level of parent interest in a preschool program are factors which also influence final decisions on program location.

MOP also makes a practice of asking parents of children leaving programs where they are going, and uses these data to monitor the movement of migrants and the duration of stay within the agency's service area. The map on the following page shows the location of the Somerton site.

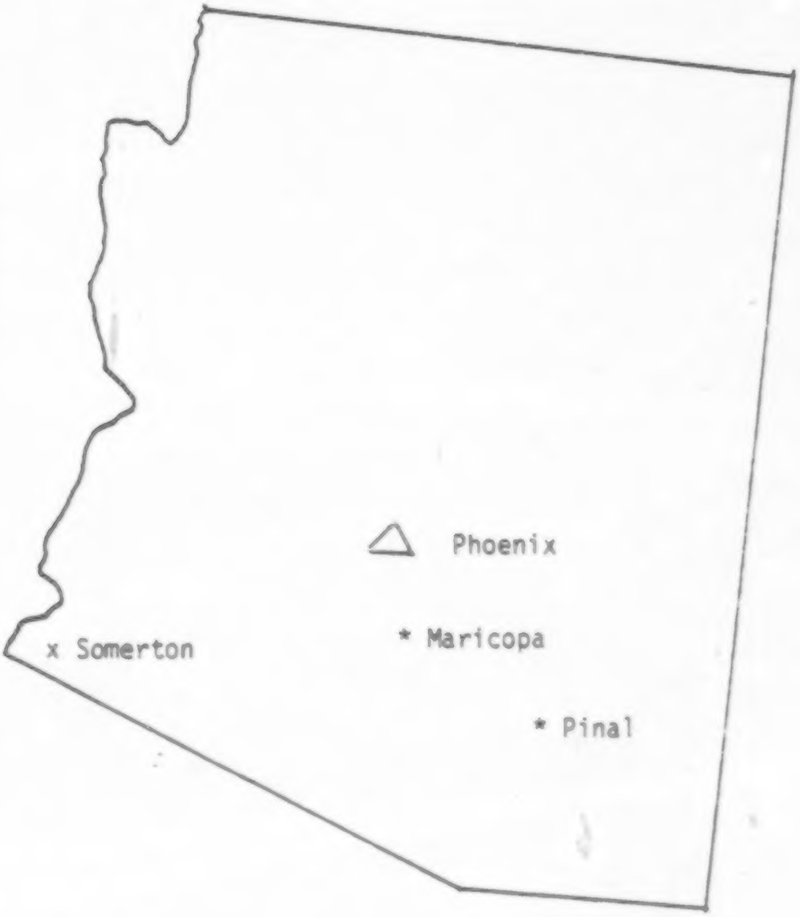
d. Adaptations to Special Needs of the Migrant Population

All of the 110 children served at MOP's Somerton center are Mexican-Americans. The teaching staff working at the center are selected to reflect the language and culture origins of children and families served. All six full-time teachers and two of four teacher's aides working at Somerton are Mexican-Americans. This staff is responsible for using the Bilingual Early Childhood Program (BECP) curriculum at the center. Other program adapations mentioned by the Head Start Coordinator are:

- Health component and dental care are heavily oriented toward specific migrant health problems, such as valley fever (due to dust) and "bottle caries" (due to the baby being put to bed with a bottle).

FIGURE 15

MOP HOME BASE CENTER LOCATIONS


△ Phoenix
x Somerton
* Maricopa
* Pinal

KEY

△ Grantee office

x Home base MHS center surveyed

* Home base MHS center not surveyed

- Mexican-American foods are served at the center and "potlucks" are used to establish contacts with parents and involve them in center activities.
- Over-enrolling is deliberately practiced to keep the enrollment at a maximum in face of the heavy turnover among enrollees whose families move frequently to find work.

It was also noted that materials were being translated into Spanish for use in parent training sessions.

MOP has a parent-run Policy Council at the grantee level which is involved in policy and funding decisions. There is also a Parent Policy Committee at the Somerton center which is actively involved in the decision-making process. Other steps taken to involve parents in activities at the center included the following:

- A parent group interviews all applicants for staff positions.
- The program makes extensive use of parent volunteers.
- Recruitment of these volunteers occurs on a continuing basis throughout the school year.
- Parents plan and hold "open houses" which are usually well attended.
- A monthly newsletter is sent to parents.
- Teams of parents are used to recruit eligible children.
- Social activities are used to present lectures on various subjects related to Head Start.

Because MOP is a multiple service agency, it is able to provide a continuum of services to migrant families once their eligibility is established by the Arizona Department of Economic Security. When migrant families leave the program, staff try to provide them with information on preschool and social service programs in areas they are moving to. Parents are also given a copy of their child's education and health records to take with them.

e. Monitoring and Support of Centers

Due to vacancies in the Education, Parent Involvement, and Health/ Handicap Coordinator positions on the Head Start Coordinator's staff, monitoring of the Somerton center and a second center operating at Pinal was the responsibility solely of the Head Start Coordinator. A limited amount of training and technical assistance was provided by outside agencies.

It should be noted that a special relationship exists here between the grantee Head Start Coordinator and the Somerton center. Because the top administrative position at the center (the center manager job) was vacant, the Head Start Coordinator exercised many of the administrative functions of a center director.

f. Problems and Difficulties

The five major problems associated with service delivery identified by the MOP Head Start Coordinator and her recommendations on how they can be solved are presented below.

1) Finding Appropriate Facilities

The difficulties mentioned here were the cost of renting, problems in negotiating a lease, and the racist opposition of building owners and certain elements in the local community.

In meeting this problem, the Program Coordinator stated that it is necessary to identify a number of alternative facilities in advance, rank them in order of preference, and begin negotiations long before the facility is to be used. She also stated that clearer guidelines on facility selection from IMPD would help. She also suggested that it may help to use the local newspapers and radio stations to inform the community of the need for facilities for MHS programs and the kinds of opposition MOP encountered from some elements in the community.

2) Health

The Program Coordinator noted the need for an active Health Advisory Committee to identify health care problems, and health providers who can be used to solve these problems. She also sees this committee as a watchdog agency which would point out conflicts of interest in this area, identify providers who refuse services to needy families who are unable to pay, and oppose the tendency merely to label rather than diagnose and treat persons with illnesses and handicaps. The establishment of a Statewide Health Advisory Committee which would perform these needed functions was recommended as one solution to this problem.

3) Parent Involvement

Parent involvement materials provided through ACYF were criticized as "too massive" and often not appropriate for Spanish-speaking parents. It was suggested that more audio-visual materials be developed along with bilingual materials which are simple in form and provide excitement as well as instruction.

4) Fiscal Management

MOP has had difficulties in developing plans and schedules for the expenditure of grant monies in the implementation of programs.

It was recommended that two or three people be sent from Washington, before money is awarded, to train staff in fiscal management and particularly in techniques for scheduling incremental program expenditures.

5) Time

The lack of sufficient time to do all the things required to make a program work effectively was also mentioned as a major problem. This complaint was coupled with the recommendation that IMPD and its grantees develop a better mutual understanding of what they expect from each other. MOP also expressed a desire for more feedback, directly from IMPD rather than through consultants, on program performance at the center level.

6. Campesinos Unidos, Inc. (CUI)

a. Structure and Organization

This grantee serves Mexican-American children and families living in southern California's Imperial Valley. Many migrant families in the area are permanent residents who move from grower to grower in the local area to find work. Others come from Texas and Arizona.

There were two IMPD-funded centers among the five home base programs operated by CUI during FY79. One was located at the migrant farmworkers organization's headquarters in Brawley. The second, an expansion program that opened in January 1979, was located at Blythe. Only the Brawley center which was serving 38 children at the time of the survey, was included in this study.

All five CUI programs operate under a Director of Child Development who reports to CUI's Executive Director. The Director of Child Development is supported by specialists in the areas of education, parent involvement, social services, and health. The chart on the next page shows the structure of the CUI program.

b. Funding - Amounts and Sources

CUI received a grant of $156,272 from IMPD for FY 1979. It also received a regular Head Start grant of $755,272.[17] An additional $30,000 came from USDA, and $20,000 in CETA funds were used by the grantee.

c. Basis for Determining Center Locations

CUI conducts assessments of possible center locations and develops profiles of alternative locations as a basis for decision-making. The two major factors in determining center locations are (1) availability of a suitable facility and (2) finding a central location that is easily accessible to the children and families served. The map on page 83 shows the location of CUI's Brawley center.

d. Adaptations to Unique Needs of Migrant Population

CUI's Child Development Director noted that center staff are required to make additional home visits to find parents and establish contacts between them and the centers. He also mentioned that low attendance of parents at meetings makes it impossible to maintain functioning advisory committees for each major service area.

Despite difficulties in contacting parents and involving them in programs, CUI does make special efforts in this area. CUI bylaws require that 51 percent of its Board of Directors be farmworkers. Eighty percent of the current membership of this Board are farmworkers, and one member is an MHS parent. CUI employs mainly Mexican-Americans on its center

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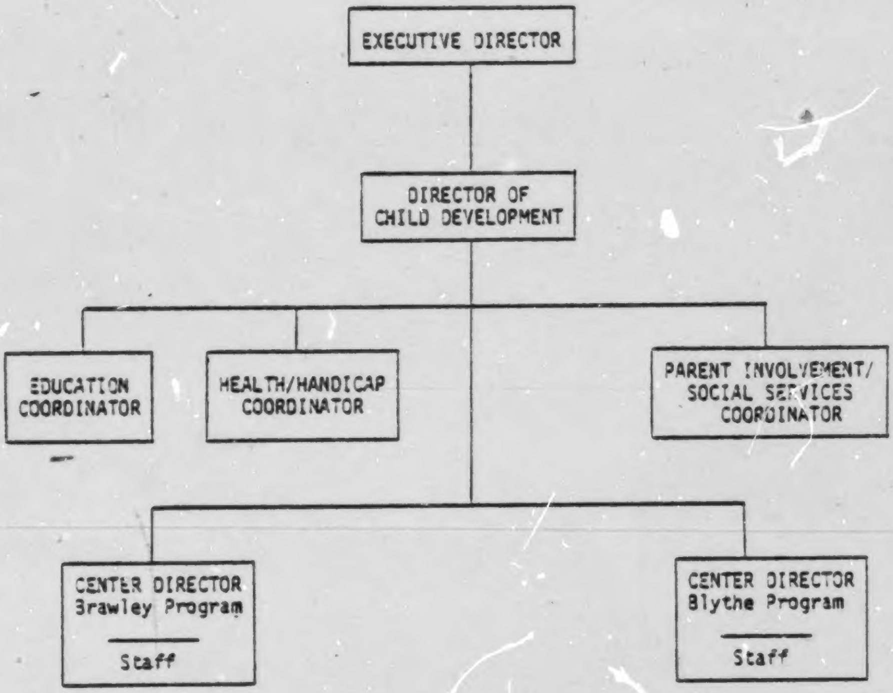
[17] CUI operates three other Head Start programs with this money at Calexico, Coachella, and Thermal.

FIGURE 16

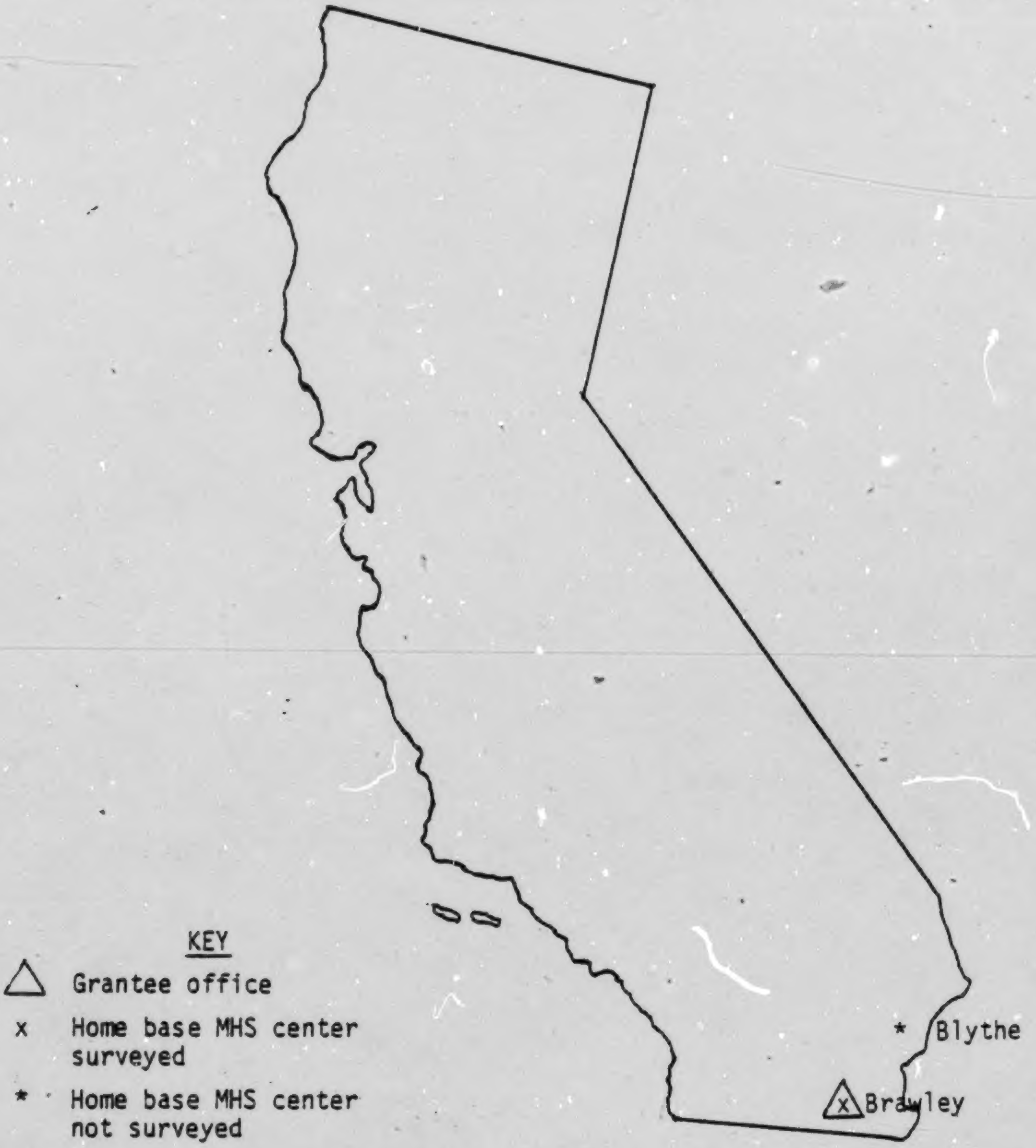
ORGANIZATION OF CUI'S MIGRANT HEAD START PROGRAM*


EXECUTIVE DIRECTOR
DIRECTOR OF CHILD DEVELOPMENT
EDUCATION COORDINATOR
HEALTH/HANDICAP COORDINATOR
PARENT INVOLVEMENT/ SOCIAL SERVICES COORDINATOR
CENTER DIRECTOR Brawley Program
Staff
CENTER DIRECTOR Blythe Program
Staff

*This chart depicts only part of the service delivery components operated by CUI.

FIGURE 17

CUI HOME BASE CENTER LOCATIONS


* Blythe
△x Brawley
KEY
△ Grantee office
x Home base MHS center surveyed
* Home base MHS center not surveyed

staff and consistently employs parents in paid positions on its programs. Its Education Coordinator is a specialist in the use of the bilingual/bicultural BECP curriculum for preschool children.

As with MOP in Arizona, other service units within the CUI organization provide support for migrant families with children enrolled in programs. These include emergency food vouchers, rental assistance, vocational training, assistance with heating bills, and tuition assistance for migrants who want to take courses offered at local colleges. When parents enroll their children at centers, they are informed of all services available through CUI and encouraged to make use of these programs.

Because CUI runs programs lasting from nine to ten months which serve families that are generally able to find farm work and remain in the area throughout this period, fluctuating enrollment, records transfer, and discontinuities in services create fewer problems here than elsewhere.

The Child Development Director did note, however, that when families do migrate, they often are unable to find another program that has openings and is oriented toward serving migrants. He stated that CUI attempts to coordinate its services with other programs that serve migrant workers.

e. Monitoring and Support of Centers

Campesinos Unidos utilizes its coordinators to monitor site-level activities and provide technical assistance. The Education Coordinator is knowledgeable about the bilingual/bicultural education curriculum for preschoolers. The Health Coordinator has responsibility for providing medical and dental check-ups and follow-up, and for seeking financial assistance from other agencies where medical costs are too high for the program alone to support. The Parent Involvement/ Social Services Coordinator makes home visits, and provides liaison between the centers and the home at all times. These specialists are responsible for monitoring and supporting the two IMPD-funded programs at Brawley and Blythe.

f. Problems and Difficulties

CUI's Director of Child Development noted three major obstacles to effective service delivery.

1) Difficulties in Finding Site Locations

This problem was traced to community and political resistance to the establishment of MHS centers in many areas. The Program Director stated that prejudice against migrant children and families was the source of this resistance. As a countermeasure, more effective public relations efforts were suggested, particularly attempts to lead communities to view the MHS centers as an economic asset.

2) Lack of Awareness on the Part of Migrants of Services Offered at MHS Centers

To solve this problem, the Program Director suggested regular contacts and closer collaboration between CUI and other social service agencies that serve migrant families. He stated that migrant clinics, California Rural Legal Assistance workers and other agencies could provide names and addresses of families with preschool children to be contacted by CUI staff. He also stated that CUI has begun to use this approach to identify potential enrollees, inform parents about programs, and recruit children.

3) Absence of Health Services for Low-Income Families

The CUI Program Director felt that areas with high concentrations of migrant workers are underserved by qualified health professionals. He added that the fees charged by these professions are so high that low-income migrant families generally cannot afford to use their services. Two answers were suggested: (a) increase health care-related funding to pay for the limited services available, and (b) establish additional clinics that serve low-income persons in the area.

B. MIGRANT HEAD START HOME BASE CENTERS

1. Number and Location

Table 9, which shows the distribution of Migrant Head Start centers by State and county, demonstrates that the vast majority (91 percent) of sites are located in Florida and Texas. Only four centers were situated outside of these States with two in southwest Georgia, one in southwest Arizona, and one in southern California. Note also that the counties range from large urban (e.g., Dade County, Florida) to sparsely populated rural (e.g., Glade County, Florida).

TABLE 9
DISTRIBUTION OF MHS HOME BASE SITES SURVEYED

Town	County*	State
FLORIDA FARMWORKERS COUNCIL		
Pompano	Broward (620,100)	Florida
Homestead	Dade (1,267,792)	Florida
Naples (2 sites)	Collier (38,040)	Florida
Immokalee	Collier (38,040)	Florida
La Belle	Hendry (11,859)	Florida
Moore Haven	Glades (3,669)	Florida
Pahokee	Palm Beach (348,993)	Florida
Belle Glade	Palm Beach (348,993)	Florida
Lake Harbor	Palm Beach (348,993)	Florida
Okeechobee	Okeechobee (11,233)	Florida
Indian Town	Martin (28,035)	Florida
Ruskin	Hillsborough (490,265)	Florida
Lake Wales	Polk (228,515)	Florida
EAST COAST MIGRANT HEAD START PROJECT		
Winter Haven (2 sites)	Polk (228,515)	Florida
Hastings	St. Johns (31,035)	Florida
East Palatka	Putnam (36,424)	Florida
Winter Garden	Orange (344,311)	Florida
SOUTHWEST GEORGIA COMMUNITY ACTION COUNCIL		
Reno	Grady (17,826)	Georgia
Baconton	Mitchell (18,956)	Georgia
MIGRANT OPPORTUNITIES		
Somerton	Yuma (60,827)	Arizona
CAMPESINOS UNIDOS		
Brawley	Imperial (74,492)	California

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*1970 Census population figures appear in parentheses.

(continued on next page)

TEXAS MIGRANT COUNCIL

Laredo	Webb (72,859)	Texas
La Grulla	Starr (17,707)	Texas
Mission	Hidalgo (181,535)	Texas
Alamo	Hidalgo (181,535)	Texas
Weslaco	Hidalgo (181,535)	Texas
Edcouch/Elsa	Hidalgo (181,535)	Texas
Raymondville	Willacy (15,570)	Texas
San Benito	Cameron (140,368)	Texas
Brownsville	Cameron (140,368)	Texas
Cotulla	LaSalle (5,014)	Texas
Carrizo Springs	Dimmit (9,039)	Texas
Crystal City	Zavala (11,370)	Texas
Eagle Pass	Maverick (18,093)	Texas
Uvalde	Uvalde (17,348)	Texas
Del Rio	Val Verde (27,471)	Texas
Ralls	Crosby (9,085)	Texas
Lubbock	Lubbock (159,000)	Texas
Hereford	Deaf Smith (18,999)	Texas
Plainview	Hale (34,137)	Texas

2. Facilities

a. Physical Structure

Home base centers operated through MHS are housed in a variety of facilities. (See Table 10.) Many programs operate out of donated facilities, occasionally in somewhat unconventional settings.

TABLE 10

TYPE OF FACILITY USED BY MHS HOME BASE PROGRAMS

Facility	Percentage of Total
Church	32.6%
Private school	32.6
Community center	14.0
Public school	11.6
Mobile home	2.3
Other	7.0
TOTAL	100.0%

Churches provided space for almost one third of the MHS home base centers. Approximately one half (45 percent) of TMC's home base centers were located in churches, while Florida Farmworkers and East Coast had at least two centers located in churches. Another 14 home base programs were located in private school facilities. These often were child development centers or reconverted private homes supported by financing and volunteer help from the community. Six centers were situated in community centers. The remaining programs occupied public school facilities, mobile homes, and old armory buildings.

b. Licenses and Permits

All MHS home base centers display the various licenses and permits required by localities to operate a child care facility. Health certificates issued by county health departments and State level agencies were evident at every center. Other certificates that appeared in centers were from local fire departments, and city or county safety bureaus, and bus driver certifications from the State highway patrol.

c. Playgrounds

Only two MHS home base centers were without playground facilities for the children. All of the playgrounds, which averaged over 20,000 square feet in size (or approximately 333 square feet per child enrolled), were fenced.

d. Other Facilities

Over 95 percent of the sites had kitchen facilities at the center. More than 80 percent of the home base centers had adapted bathroom facilities for preschool children. There were nursery facilities at 14 of the centers.

3. Program Administration

The average length of time that Migrant Head Start home base centers had operated at the same site was 4.3 years. Only seven centers had been in their current location for one year or less, while more than half of the centers had been located in the same facility for at least four years.

Although home base centers, in general, are in operation between the months of October and May, the actual dates vary from year to year depending on local crop conditions and fluctuations in the migrant population in home base areas.

One center from TMC opened in late August 1978. But most centers began providing services in late September and October. Two centers from TMC did not open until February 1979. The centers operated by SWGA and two FFC centers were open year-round.

Approximately one half of the centers which were not open all year closed in May. The other half closed in June.

Overall, MHS home base centers provided an average of 152 days of service delivery during a typical eight-month period.[18] (See Table 11.) Four centers (two from FFC and both from SWGA) were open year round. Two of TMC's home base centers were in operation for less than 100 days. However, TMC's model of service delivery provides for center staff to work part of the year at a home base site and part of the year at a destination area site upstream. Therefore, certain home base sites may delay opening so that staff can continue to work at a destination area site. Similarly, certain sites may close early so that staff can move northward to open a destination area site.

TABLE 11

LENGTH OF PROGRAM YEAR AT HOME BASE CENTERS

Grantee	Months of Operation	Service Days
SWGA	12.0	240
MOP	10.0	163
FFC	9.6	177
CUI	9.0	150
ECMP	8.6	142
TMC	7.2	130

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[18] Service delivery days exclude major holidays (Columbus Day, Veteran's Day, Thanksgiving, Christmas, New Year's, Washington's Birthday, and Easter). In addition, the day after Thanksgiving, the week between Christmas and New Year's and Good Friday were excluded. No provision in the calculation was made for a "spring break."

All home base centers were open Monday through Friday. Some centers opened as early as 6:00 a.m. but most opened between 7:00 and 7:30 a.m. Almost two thirds of the centers closed after 4:00 p.m., with ten centers closing as late as 5:30 p.m. The average number of hours that home base centers were open is 8.8 hours a day. (See Table 12.)

TABLE 12

AVERAGE HOURS OF DAILY OPERATION AT HOME BASE CENTERS

Grantee	Hours Per Day*
FFC	10.0
ECMP	10.7
SWGA	8.5
TMC	7.6
MOP	9.0
CUI	5.5
TOTAL	8.8

*These figures do not include the time it takes to transport the children between their homes and centers.

The number of hours a center operated each day varied widely. For example, one TMC center was open less than five hours a day, while one FFC site was open for 12 hours a day.

Twelve MHS home base centers offered a Head Start home-based option. A home-based option uses parents to guide the education and development of their own children; materials and periodic assistance are furnished by Head Start. The parent's home is used as the learning environment. At least one center each from TMC, MOP, ECMP, and FFC exercised this option.

4. Enrollment

a. General

A total of 2,594 children were enrolled in the 43 home base programs surveyed. Table 13 provides a breakdown of enrollment figures for the six IMPD grantees operating home base programs.

TABLE 13

ENROLLMENT AT HOME BASE CENTERS SURVEYED

Grantee	Centers	Children Enrolled	Average Enrollment Per Center
TMC	20	1,492	75
FFC	14	589	42
ECMP	5	250	50
SWGA	2	115	57
MOP	1	110	110
CUI	1	38	38
TOTAL	43	2,594	60

The Texas Migrant Council and Florida Farmworkers Council, which together operated 34 sites serving 2,081 children, are the largest service providers among the six grantees. At the other extreme are Migrant Opportunities, Inc., in Arizona and Campesinos Unidos, Inc., in southern California. One site from each was included in the survey.[19] They served a combined total of 148 children.

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[19] See the individual grantee discussions for the description of the centers operated by a grantee.

Among grantees with more than one site, TMC had the highest enrollment per center. It averaged 75 children at each site; FFC, the next largest grantee, had an average of 42 children at its sites.

b. Ethnicity

The following table presents the ethnic groupings of the children at home base centers.

TABLE 14

ETHNICITY OF CHILDREN ENROLLED AT HOME BASE CENTERS

Ethnic Group	Number	Percent of Total
Hispanic	1,954	75.3%
Black/Negro (not of Hispanic origin)	555	21.4
Caucasian/White (not of Hispanic origin)	84	3.2
Asian or Pacific Islander	1	*
American Indian or Alaskan Native	-	-
TOTAL	2,594	100.0%

*Less than 0.1 percent.

Hispanic children comprised over three quarters of the enrollment of MHS home base centers. Nearly all of these children (99.5 percent) were Mexican-Americans. Only eight Puerto Ricans were enrolled in these centers at the time of our visits. There were also two West Indian Hispanics.

One hundred and six handicapped children were enrolled at MHS centers. This represents approximately four percent of total enrollment. Eleven centers had no handicapped children. The largest handicapped enrollment (17 children) was at the MOP center in Somerton, Arizona.

c. Age of Enrollees

The following table presents the number of children above and below three years of age served by each grantee.

TABLE 15

AGE OF CHILDREN ENROLLED AT HOME BASE PROGRAMS

	Children Less Than 3 Years Old		Children More Than 3 Years Old	
Grantee	Number	Percentage	Number	Percentage
FFC	140	23.8%	449	76.2%
ECMP	121	48.4	129	51.6%
SWGA	-	-	115	100.0%
TMC	54	3.6	1,438	96.4%
MOP	-	-	110	100.0%
CUI	-	-	38	100.0%
TOTAL	315	12.1%	2,279	87.9%

One of every nine children served by MHS home base programs was under three years of age. Twenty-seven home base centers served 315 such children.

All of the centers from FFC and ECMP reported serving children under three. Three grantees (SWGA, MOP, and CUI) reported that no children under three were enrolled. Seven TMC centers served this group of children. Only four centers required that children under three have an older brother or sister enrolled in the same program.

The highest concentration of children under three was found at centers operated by ECMP, which served an average of 24 children under three at each center. Two centers operated by East Coast served only infants and toddlers.

d. Previous Head Start Experience

Children at MHS home base centers with previous Head Start experience number 981 or 37.8 percent of the total enrollment. This figure includes children who were enrolled in the same program last year, as well as those who transferred from another Head Start program. One half of the enrollees at the center operated by Campesinos Unidos, the grantee with the highest proportion, had been exposed to Head Start in the past. Less than two percent of the enrollees at the SWGA centers had previous Head Start experience.

e. Eligibility of Enrollees

Since Migrant Head Start programs are designed to serve the children of migrant farmworkers, the Indian and Migrant Program Division of ACYF, which funds MHS grantees, has developed the following operational definition for migrant farmworkers in order to determine the eligibility status of applicants:

> Migrant farmworkers are those who:
>
> a. Left their home temporarily overnight to do hired farm work in a different county within the same State or in a different State with the expectation of eventually returning home, or

b. Had no usual place of residence and do hired farm work in two or more counties during the year.[20]

Most of the children receiving services through MHS programs are eligible under the IMPD definition of migrant farmworker. Overall, 1,907 of the children (76 percent) enrolled in home base programs were eligible, according to center directors. (See Table 16.)

TABLE 16

ENROLLEES MEETING ELIGIBILITY REQUIREMENTS AT HOME BASE PROGRAMS

Grantee	Eligible Enrollees	Percentage of IMPD-Funded Children
CUI	41	93.2%
FFC*	273	46.0%
TMC	1,300	92.1%
ECMP**	212	85.8%
MOP	78	89.7%
SWGA	3	2.7%
TOTAL	1,907	76.5%

*Two center directors did not know how many of their children met the definition.

**One center director did not respond to this question.

It should be stated here that not all centers surveyed served IMPD-funded children only. Three grantees (FFC, SWGA, and TMC) operated centers which served both IMPD-funded and other children.

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[20] IMPD uses this definition from The Hired Farm Working Force of 1975, Economic Research Service, U.S. Department of Agriculture.

The sources of funding for these other children included regular Head Start and Title XX.

All of the children served by CUI and the vast majority of those at FFC, TMC, and ECMP centers were eligible. Almost three quarters of MOP's children met the criteria for eligibility. The striking case here is SWGA, which reported only three children meeting the IMPD definition.

f. Transportation

Since MHS home base programs are located in rural localities, it is necessary to transport many of the enrollees. In fact, almost 85 percent of all home base enrollees were transported to and from the center each day over a mean distance of 6.2 miles. The longest bus rides occurred at centers operated by Southwest Georgia where most children were transported an average of 20 miles every day. More than one half of the 43 programs reported having to transport at least one child more than ten miles between a center and the child's house.

g. Waiting Lists

MHS centers receiving more applications for enrollment than they are able to accept are required to maintain a waiting list. Whenever a child leaves the program, this list is used to fill the recent vacancy. Waiting lists were maintained at 26 MHS home base centers. A total of 560 children whose parents qualified as migrant farmworkers had not been able to enroll in MHS home base programs due to lack of space since the centers opened this session.

5. Center Relationships with Public Schools

There is some interaction between the majority of MHS home base centers and the local public school system. More than half of the 25 centers which have this relationship use equipment from the local public school. (See Table 17.)

TABLE 17

ASSISTANCE TO HOME BASE CENTERS BY LOCAL SCHOOL SYSTEMS

Types of Assistance	Percentage of All Centers Assisted
Use of equipment	56.0%
Administrative assistance	12.0%
Transportation assistance	12.0%
Use of building	8.0%
Use of consultants	8.0%
Use of teachers	8.0%
Use of offices	4.0%
Other	44.0%

Equipment lent by the public schools to MHS home base centers consisted primarily of teaching materials, art supplies, puzzles, games and books, and toys for use on the playground. One FFC center noted that the equipment lent by their public school district was designed for handicapped children.

Other assistance from local schools included the use of specialized personnel and student volunteers. A SWGA center utilized speech therapists from local schools, school nurses were utilized by two centers from TMC and CUI, and students from local high schools volunteered their time at centers from FFC and ECMP.

Other assistance also included donations by the public school system of:

- Overnight parking privileges on school property (ECMP);
- Free announcements in the high school newspaper (ECMP); and
- The lot on which a center was located (FFC).

Since MHS enrollees are usually exposed to life experience quite different from those of non-migrant preschoolers, it is important for centers to assist them in their transition to the public school system. All but five centers took steps to assist children to make the transition to the public schools. Nearly three quarters of the programs which assist in this area transfer education and health reports to public school systems.

Meetings with parents of children entering the public school system are used as a method of assistance at nearly one third of these sites. The staff from six centers meet with the children's future teachers. Teachers were not the only personnel from local schools contacted by home base centers. Persons responsible for registering new students were given the names, addresses, and other pertinent background information on MHS children. One center also reported meeting with the principal and superintendent of the local schools.

TMC and FFC centers took the children on field trips to the public schools during their last year at the MHS program. The MOP center reported an interesting variation -- center staff there invite teachers from the public schools to visit and observe MHS activities. One FFC center introduces students to the curriculum used by the local schools.

6. Transfer of Records

Continuity of educational experiences and health care is one of the primary goals of MHS programs. Maintaining continuity in this context requires the transfer of records when children go to a program in another location or enter the public school system.

Almost 90 percent of the MHS home base centers transfer records. Three quarters of the programs indicated that they send the child's records with the parents. The Migrant Student Record Transfer System (MSRTS) was used at 16 centers, while ten centers said they sent records to programs that request them.

For the 981 children with previous Head Start experience, only 309 sets of records (31.5 percent) were forwarded to the 18 home base programs serving the children. Records were available at the time the child enrolled at only 13 centers and were received within two weeks of enrollment at two other centers. Two programs reported that it took between two and four weeks after enrollment for the records to arrive. Records did not arrive at one center for more than a month.

C. PROFILE OF PROGRAM STAFF

1. Number and Positions of Center Staff

MHS home base centers had 952 staff members (including volunteers and consultants) according to the center directors. Six hundred and twenty were paid employees and the remainder were volunteers or consultants. The following table breaks down the number of paid staff by position and indicates the percentage of staff working in each position by grantee.

TABLE 18

PAID MHS HOME BASE STAFF

	FFC		ECMP		SMGA		TMC		MOP		CUI		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Teacher's Aides*	94	54.0	48	48.0	6	24.0	70	25.8	4	16.7	9	34.6	231	37.2
Teachers	5	2.9	4	4.0	6	24.0	73	26.9	7	2.9	3	11.5	98	15.8
Support Personnel	21	12.1	20	20.0	5	20.0	29	10.7	3	12.5	3	11.5	81	13.1
Administrators	17	9.8	5	5.0	2	8.0	36	13.3	1	4.2	4	15.4	65	10.5
Other	14	8.0	2	2.0	2	8.0	16	5.9	8	33.3	1	3.8	43	6.9
Nutrition Aides	6	3.4	6	6.0	2	8.0	14	5.1	-	-	2	7.7	30	4.8
Health Aides	2	1.1	4	4.0	-	-	18	6.6	1	4.2	1	3.8	26	4.2
Health Professionals	-	-	4	4.0	1	4.0	5	1.8	-	-	-	-	10	1.6
Social Service Aides	4	2.3	3	3.0	-	-	2	.7	-	-	1	3.8	10	1.6
Parent Involvement Specialists	2	1.1	2	2.0	-	-	4	1.5	-	-	1	3.8	9	1.5
Social Service Professionals	5	2.9	1	1.0	1	4.0	1	.4	-	-	1	3.8	9	1.5
Nutrition Professionals	4	2.3	1	1.0	-	-	3	1.1	-	-	-	-	8	1.3
TOTAL	174	100.0	100	100.0	25	100.0	271	100.0	24	100.0	26	100.0	620	100.0

*Twenty-three persons responsible for infants and toddlers at two ECMP centers were "care-givers" who have been classified here as teacher's aides.

As Table 18 shows, teachers and teacher's aides comprised 53 percent of the total staff. The highest percentage of MHS employees were teacher's aides (37.2 percent.) Teachers and teacher's aides comprised between 39.3 percent (MOP) and 66.6 percent (FFC) of the total staff at each grantee. The average number of staff positions per center ranged from 15 at Texas Migrant Council sites to 26 at the CUI center and 28 at the MOP center.

Less than two percent of all full-time employees were health professionals. This same was true for nutrition professionals, social service professionals, social service aides, and parent involvement specialists.

Much of the data that follows was obtained from center records available for 83 percent of the paid staff (See: Appendix H. Tables C-1-C-12)

2. Ages of the Staff

The average age of paid staff members at home base programs was 32 years old. The age of the staff did not vary greatly among grantees. Sixty-five percent were between the ages of 21 and 35. Of the remaining staff, seven percent were below 20 years of age, 15 percent were between 36 and 40, and 19 percent were above 40 years of age.

3. Sex of the Staff

Females comprised 84 percent of the overall staff. Across grantees, the sex of the staff differed greatly. ECMP had the largest proportion of females (95 percent), while CUI had the lowest (6.3 percent).

4. Work Status

Among the 620 paid employees who worked at MHS home base programs, 574 (93 percent) were full-time and 46 (seven percent) were part-time workers. Table 19 provides a breakdown for all paid employees by position.

TABLE 19

WORK STATUS OF HOME BASE STAFF

Position	Full-Time		Part-Time		Total	
	No.	%	No.	%	No.	%
Teacher's Aides	226	39.4	5	10.9	231	37.3
Teachers	97	16.9	1	2.2	98	15.8
Support Personnel	70	12.2	11	23.9	81	13.1
Administrators	64	11.1	1	2.2	65	10.5
Other	36	6.3	7	15.2	43	6.9
Nutrition Aides	25	4.4	5	10.9	30	4.8
Health Aides	24	4.2	2	4.3	26	4.2
Health Professionals	5	.9	5	10.9	10	1.6
Social Service Aides	8	1.4	2	4.3	10	1.6
Parent Involvement Specialists	5	.9	4	8.7	9	1.4
Social Service Professionals	8	1.4	1	2.2	9	1.4
Nutrition Professionals	6	1.0	2	4.3	8	1.3
TOTAL	574	92.6	46	7.4	620	100.0

All of the staff members at CUI and SWGA worked full-time. Ninety-five percent of TMC and ECMP staff were full-time employees; 89 percent of FFC's Staff and 82 percent of MOP's staff worked full-time.

5. Salary

The average salary for full-time employees working at MHS home base centers during the 1978-1979 program year was $6,786.[21] Salaries of paid staff members varied considerably across grantees. For example, typical salaries of staff at the CUI center were $10,291; at FFC centers, $7,571; at TMC centers, $6,493; at the MOP center, $6,133; and $5,190 at ECMP centers. No salaries for SWGA's staff were available at the centers.

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[21] Wages are stated in annual salary equivalents for comparative purposes.

6. Ethnic Background of Staff

The following table shows the ethnicity of paid staff at the 43 home base sites.

TABLE 20
ETHNICITY OF STAFF AT HOME BASE CENTERS

	Hispanic		Black/Negro (not of Hispanic Origin)		White/Caucasian (not of Hispanic Origin)		Asians and Pacific Islanders	
Position	No.	%	No.	%	No.	%	No.	%
Administrators	41	10.2	19	12.3	5	8.2	-	-
Teachers	85	21.1	8	5.2	4	6.6	1	100.0
Teacher's Aides	132	32.7	77	49.7	22	36.1	-	-
Other Professional Staff	27	6.7	9	5.8	14	23.0	-	-
Other Para-Professional Staff	59	14.6	8	5.2	13	21.3	-	-
Support Personnel	59	14.6	34	21.9	3	4.9	-	-
TOTAL	403	65.0	155	25.0	61	9.8	1	.2

Slightly more than 65 percent of the paid staff were Hispanic. Hispanic and black staff members account for more than 90 percent of the total MHS staff.

Ethnicity of staff members at MHS home base centers, like ethnicity of enrollees, varied a great deal by grantee. For instance, TMC's staff was 99 percent Hispanic, while SWGA's staff was 52 percent black and 48 percent white. Hispanics comprised 92 percent of CUI's staff while blacks and Asians accounted for four percent each. MOP's staff was 58 percent Hispanic and 42 percent white. ECMP's staff was fairly evenly distributed among blacks (42 percent), Hispanics (33 percent), and whites (25 percent). The staff at FFC centers consisted of blacks (57 percent), Hispanics (36 percent), and whites (seven percent).

7. Spanish-Speaking Staff

According to the records, 57 percent of the paid staff at MHS home base centers spoke Spanish.[22] Three grantees which operated 76.7 percent of all MHS centers used a majority of Spanish-speaking staff. CUI had the highest percentage of staff who spoke Spanish (94 percent). SWGA, which serves English-speaking children, had no Spanish-speaking staff. Approximately 87 percent of the staff spoke Spanish at MOP and TMC sites. Twenty-five percent of ECMP and 23 percent of FFC staffs, which mainly serve English-speaking children, were able to speak Spanish.

8. Highest Degrees Obtained

Staff records from MHS home base centers indicate that 48 percent of all staff received a high school degree or equivalent. Four-year college degrees were obtained by five percent of the total. One out of ten of the five percent who received a college degree went on to receive a graduate degree.

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[22] This figure probably underestimates the number of staff who actually spoke Spanish since not all centers collected this information in their staff and program records.

9. Certification

Certification of staff members as Child Development Associates (CDAs) was encountered more frequently than other types of certification. According to staff records, approximately five percent of administrators, teachers, and other personnel directly involved in service delivery had received a CDA. Other certificates that were kept on record included those for Bilingual/Bicultural CDAs, State certifications, Palatisha certificates,[23] nursing licenses, Red Cross First Aid certificates, and other certificates for specialized training.

10. Health Screening

A record of health screening was found for 68.7 percent of the total MHS home base staff. Approximately three quarters of the staff members from FFC, SWGA, and TMC had a record of health screenings at the centers. A little less than one half of the staffs from CUI and ECMP had the same record. According to the center records, all of the staff members at MOP had health screenings.

11. Length of Head Start Employment

Records indicate that 43.8 percent of all MHS home base staff had been employed at Head Start centers for one year or less. One third of these people had held their jobs between two and four years. The remaining 23 percent for which information was obtained had worked at Head Start centers for five years or more.

12. Length of Other Preschool Employment

Records of MHS home base centers showed that 58 percent of the staff had less than one year of other preschool experience. Another 30 percent of the staff had between two and four years of experience, and 12 percent had more than four years of experience.

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[23] This certificate is awarded to individuals who have received special training in working with handicapped children.

13. Volunteers Working at Centers

Center directors reported a total of 325 volunteers contributing their services to MHS home base programs. Of these, 234 (72 percent) were parents of children enrolled, while the other 91 (28 percent) were non-parent volunteers.

a. Parent Volunteers

All grantees reported receiving volunteer services from parents. These services were received by 44.2 percent of MHS home base centers. Parent volunteers were utilized at all of the CUI, MOP, and SWGA sites. Ten TMC, four FFC, and one ECMP center had parents of enrollees volunteer their services. Parent volunteers provided varied services. Many parent volunteers (46.2 percent) worked as teacher's aides; fewer worked as social service/parent involvement aides (3.4 percent), clerical aides (0.9 percent), and health aides (0.4 percent). The remaining half of the parent volunteers also worked as kitchen helpers, fund raisers, or as general help.

b. Non-Parent Volunteers

Non-parent volunteers were reported working at almost one half (46.5 percent) of MHS home base centers. All of the centers operated by CUI and SWGA had non-parent volunteers working there. Almost one half of TMC centers (45 percent) and FFC centers (43 percent) received non-parent volunteer assistance. One of the five of ECMP's centers had non-parent volunteers.

Almost two thirds of the non-parent volunteers were working as teacher's aides at MHS home base centers. They also worked as social service/parent involvement aides, health aides, and clerical aides.

The major sources of non-parent volunteers were CETA (43 percent), VISTA (13 percent), and Neighborhood Youth Corps (five percent), all of whom were classified by the centers as "volunteers" because they were not paid from center funds. The remaining non-parent volunteers were primarily high school students. One center reported receiving volunteer services from a local college.

14. Consultants Employed by Home Base Centers

Consultants were on the staff of three MHS centers. FFC had one nutrition consultant on its staff and ECMP used the services of two health professionals. MOP used four consultants: three health professionals and one nutrition professional.

15. Staff Training

Paid staff at MHS home base centers each received 28 hours of training. Preservice training accounted for 15 hours and inservice training for approximately 13 hours.

As Table 21 depicts, there were considerable variations among grantees in the amount of training provided.

TABLE 21

TRAINING PROVIDED TO PAID STAFF OF HOME BASE CENTERS

Grantee	Hours of Preservice Training	Hours of Inservice Training	Total Hours of Training
MOP	26.3	18.6	44.9
SWGA	2.7	29.8	32.5
ECMP	23.7	8.7	32.4
FFC	11.3	9.0	20.3
TMC	11.4	8.8	20.2
CUI	15.6	1.6	17.7
AVERAGE HOURS	15.2	12.8	28.0

MOP's staff received more training than any other grantee's. More preservice training was given to MOP's staff than any other, while SWGA's staff received the most inservice training.

D. PERFORMANCE AND SERVICE OUTPUTS IN THE FIVE MAIN SERVICE AREAS

1. Program Administration

a. Role and Responsibilities of the Center Director

Center directors have overall responsibility for day-to-day program activities at the site level. Their position is primarily administrative. They are responsible for the record-keeping and reporting functions of the centers. They also oversee the disbursement of funds through center cash accounts and write purchase orders.

Activities in all Head Start service areas at the site level are coordinated by center directors. Center staff are supervised by this staff member. Staff training and evaluations are coordinated through this person.

Recruiting, screening, interviewing, and hiring center staff are usually functions of the center director. Food purchasing, in conjunction with the cook, at centers with kitchen facilities may also be a responsibility of the center director. In the cases where there are no parent involvement and social services specialists at the centers, center directors often exercise personal responsibility for performance in these areas.

b. Profile of Center Directors

Thirty of the center directors at the 43 sites surveyed were women. Twenty-five center directors were Hispanic (all but one were Mexican-American), 14 were black, and four were white.

Center directors were predominantly young. Their average age was 33. More than 50 percent were under 30 years of age, while less than five percent were over 50 years old.

English was the primary language of approximately one half of the center directors, while Spanish was the primary language of the other half. All of the center directors who cited Spanish as a first language indicated that English was their second language. Five center directors whose primary language was English cited Spanish as their second language.

Center directors averaged almost two years of formal education beyond high school. All had attained at least a GED. Most attended college. Seven held two-year degrees. Eleven had graduated from college, two had Master's degrees, and one had a Ph.D.

Center directors at the 43 home base sites had an average of almost four years' experience in their current position. Twelve of them were relatively new to the position, however, with one year or less of experience.

Most center directors had not held previous positions where they currently worked. This is evidenced by the fact that the mean length of employment at the centers was only slightly longer (a little more than four years) than the amount of time spent in their current position. This does not imply that their only experience with MHS was with the center where they currently worked, however. In fact, approximately 50 percent indicated that they had worked at other MHS centers for a mean of three years. Seventeen indicated that they had other preschool experience that averaged approximately eight months.

Nineteen center directors were continuing their education by taking courses related to their jobs. One was working on attaining a Palatisha Certificate, 11 were working on Child Development Associate (CDA) degrees, six on the Bilingual/Bicultural CDA, and one on State certification. Six others were studying for other credentials including:

- Early Childhood Education degrees (2),
- Spanish courses (2),
- Parent Effectiveness Training, and
- Certification for nutritional training.

Credentials received by center directors include nine CDAs, one Bilingual/Bicultural CDA, one State certification (Florida), and six other certificates including:

- Learning disabilities workshop certificates (3),
- Polk County (Florida) Early Childhood certification,
- Child care certification, and
- First aid.

2. Education

a. Profile of Teaching Staff

1) Overall Staff

A total of 97 teachers and 226 teacher's aides were employed on a full-time basis at home base centers. (See Table 22.) A typical Migrant Head Start center had a teaching staff of between six and seven, with teacher's aides outnumbering teachers two to one. The centers had a 1:7 ratio of teaching staff to children.

Full-time teaching staffs at home base centers were augmented by six part-time staff and 52 volunteers. At the two ECMP centers serving only infants and toddlers, one teacher and 23 full-time care givers cared for the children enrolled.

TABLE 22

TEACHING STAFF AT HOME BASE CENTERS

		FFC	ECMP	SWGA	TMC	MOP	CUI	Total
Full-Time Staff	Teachers	5	4	6	73	6	3	97
(N=323)	Teacher's Aides	92	45	6	70	4	9	226
Part-Time Staff	Teachers	-	-	-	-	1	-	1
(N=6)	Teacher's Aides	2	3	-	-	-	-	5
Volunteers	Teachers	-	-	-	-	-	-	-
(N=52)	Teacher's Aides	26	2	3	21	-	-	52
TOTAL		125	54	15	164	11	12	381

Home base centers were generally staffed with full-time teaching personnel. Only two percent of educational staff were considered part-time. All grantees with the exception of MOP and CUI used some volunteers in teaching positions. However, most were part-time.

The Florida Farmworkers Council staffing pattern is unique among the six grantees. An assistant coordinator at each of the 14 FFC sites, working under the direction of a center coordinator (who is equivalent to the center director found in the other programs), supervised a teaching staff composed exclusively of teacher's aides. ECMP instruction programs are somewhat similar in that their three preschool programs are directed by a head teacher who oversees the work of a staff consisting entirely of teacher's aides. The teaching staffs of the remaining four grantees were made up of a mixture of teachers and teacher's aides supervised by a head teacher.

Florida Farmworkers Council also made the most extensive use of volunteer classroom staff. At its 14 centers, 26 volunteers worked as teacher's aides. Most of these were supported by CETA funds. In addition to CETA, Senior Citizens and Foster Grandparents programs were also a primary source of volunteers for other grantees.

2) Head Teachers

Responsibility at the centers for the educational component of Migrant Head Start programs is generally exercised by head teachers. All grantees except Florida Farmworkers Council use this designation. As noted above, at FFC sites an assistant to the center coordinator supervises the teaching staff.

At three of the 43 centers, the head teacher's role was temporarily filled by a regular teacher. A center director was serving as the head teacher at one site.

Among persons working as head teachers, 34 (79 percent) were women.[24] Twenty-four were Hispanics (mainly Mexican-Americans) and 16 were blacks. Two were whites, and one was an Asian-American.

Head teachers at MHS home base centers were relatively young, averaging 32 years of age. Approximately one half of the head teachers were under 30 years of age, while only about five percent of all respondents were over 50 years old.

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[24] Hereafter, head teacher will be used to refer to the 43 persons performing the duties associated with this position, regardless of differences in job titles.

English was the primary language of 24 head teachers. Over 70 percent of these 24 were from centers operated by Southwest Georgia, East Coast, and Florida Farmworkers. Spanish is the mother tongue of the other 19. All 19 of this latter group were bilingual, while only five head teachers whose primary language is English were fluent in Spanish.

In general, head teachers had completed almost a year of post-high school education. Twenty-two had high school diplomas, and six had attained the equivalent through GED certificates. Four held two-year college degrees, five had completed a four-year college course, and one had a Master's degree.

Head teachers had an average of two and one half years of experience in their current jobs. However, 21 had served as head teachers for less than one year.

Head teachers employed at home base centers were a relatively inexperienced group. They had worked at the center where they were employed for a mean of eight months in another capacity (usually as teachers or teacher's aides) before assuming their current responsibilities. Fourteen (33 percent) had an average of 11 months' experience at other Migrant Head Start centers. Nineteen head teachers had an average of 17 months of related preschool experience apart from their work in Migrant Head Start programs.

One third of the head teachers at home base centers are continuing their education by taking courses related to their jobs. Among the 43 persons exercising supervisory responsibility over educational activities, 22 (51 percent) were either working on or had received a Child Development Associate certificate. Eleven had received the regular CDA certificate and eleven were taking CDA courses for credit.

b. Preservice and Inservice Training of Teaching Staff

All six grantees provided some form of both preservice and inservice training for teaching staff at most sites. The majority of this training was given by grantee staff, but outside training organizations were also called upon.

ECMP provided a minimum of 16 hours of preservice training to staff at each of its five centers. In most cases, training lasted three days or more. These training sessions, which covered all five major program components, were led by staff from ECMP's office in Orlando, Florida. Outside consultants were used to assist in this training.

ECMP provided two to three hours of inservice training on a monthly basis at its centers. This training was given by an education coordinator from Orlando.

The Florida Farmworkers Council used its own central office staff for all preservice training. Preservice training of FFC teacher's aides included most staff members and focused on child development theory and practical methods for directing classroom learning activities. Approximately 20 hours of preservice training were provided by grantee staff at centers receiving this training. Staff at two centers did not receive preservice training.

Inservice training was provided by grantee staff at 11 of the 14 FFC centers. Training consisted mainly of (1) continuing assistance in the development of lesson plans and the direction of classroom activities, and (2) training of one or more staff in how to identify the educational needs of handicapped children and develop individualized education plans for these children. FFC also used specialists from the

Mailman Center at the University of Miami to provide inservice training at several centers on how to screen children to identify developmental disabilities.

Staff at one of Southwest Georgia's sites received no preservice training; all teachers at the second site received eight hours of training focusing on lesson planning and techniques for directing classroom activities. Grantee specialists provided this training and followed up with monthly inservice training sessions at both sites which lasted from one to two hours.

At the 20 sites both the TMC central and regional office staff provided preservice training in lesson planning and the direction of classroom activities within the framework of the Bilingual Early Childhood Program (BECP). This curriculum was used at all 20 TMC sites. TMC also trained center staff in methods of providing effective educational programs for handicapped children.

TMC made extensive use of early childhood development specialists from the Southwest Early Development Laboratory (SEDL) in the preservice training of teachers and teacher's aides. SEDL also conducted workshops on educating the handicapped for teachers in four programs. Preservice training focusing on handicapped children was provided at one center by a crippled children's clinic.

Inservice training of teachers and teacher's aides at TMC sites was given both by grantee specialists and by center directors and head teachers working at the site level. The frequency of the training by center directors and head teachers, who were the source of much of the inservice training provided, varied; some head teachers stated that it occurred daily, some held weekly training sessions, and some provided training once each month. A limited amount of inservice training was provided by SEDL. Specialists from the Portage Project sponsored by the University of Wisconsin provided training in developmental assessment and teaching the handicapped at several sites. VISTA volunteers trained staff in the area of mental health at one center. The Texas State Mental Health and Mental Retardation Agency provided mental health training at two others.

The IMPD grantee in Arizona, Migrant Opportunities, Inc. (MOP), provided eight hours of orientation training for its six teachers and four teacher's aides. The education staff received 32 hours of preservice training in the education of handicapped children from Project Palatisha personnel.

At the Campesinos Unidos site, two teachers and three teacher's aides received 13 hours of preservice training. The Westinghouse Corporation provided an additional 24 hours of training for the head teacher in the areas of nutrition, health, parent involvement, and social services.

CUI and MOP, the two smallest programs supported by IMPD funds, were the only grantees which did not themselves provide inservice training. CUI is the only grantee which used outside sources exclusively for both preservice and inservice training.

c. Classroom Configurations and Child Groupings

As noted earlier, there were 182 classes in the 43 home base centers. An average center had four classes. Eight centers had only two classes and the largest had 11. Class enrollments ranged from three to 44 and averaged 16.

At the 41 centers serving preschool children, 20 used a traditional classroom setup and 21 used an open configuration. The two ECMP centers serving infants and toddlers had no classrooms.

Groupings and organization for group interaction in classes vary across MHS home base centers. A series of observations on class groupings made in the course of a day at each center is presented in the following table.

TABLE 23

CLASS GROUPINGS OBSERVED

Type of Grouping	Number of Centers	Percent of Total
Fixed small group clusters	34	79.1%
Whole class clustered	30	70.0%
Dyadic activities	28	65.1%
Teacher with single subgroup; rest of class in freeplay	22	51.1%
Fluid small group clusters	20	46.5%
Unrestricted movement	19	44.1%
Children engaged in solitary play	15	34.9%

The age and developmental level of the child are the two factors which determine the grouping of children in most instructional programs. Generally, age is the prime factor; developmental testing results were used to determine whether exceptional children should be moved ahead or held back at 14 sites. At two centers children were grouped by primary language as well as by age, and at nine other centers grouping changed depending on the activity in which children were participating. In nearly all centers (38), class grouping remained constant throughout the day. The major exception was the CUI program where groupings changed during the day depending on the activity in which the children were engaged.

d. Curriculum

Some form of formal curriculum was followed in classrooms at 40 sites.[25] Curriculum selection varied widely from grantee to grantee, and often from center to center within a single grantee's operations. At a number of centers more than one curriculum was used, depending on the age of children receiving instruction and the preferences of the teaching staff. Among the 14 FFC centers considerable diversity in the choice and use of curriculum was evident. The Southwest Laboratory's Kit was used at nine FCC sites (mainly for three- to four-year-olds); the Bridge to Reading curriculum was used for the four- to five-year-old group at eight centers. Versions of the Peabody curriculum suitable for children ranging from two to six years were being followed in four FFC programs. Other curricula followed in one or more FFC classrooms were: the Camp curriculum; Early Childhood Systems; Premooning; Oscar Prereading; and Sound Table.

The three ECMP programs serving children from three to five years also used and sometimes combined different curricula. These were the Peabody, My Friends and Me, and Peek Kits. One head teacher also mentioned using a Tools for Learning Kit.

One of SWGA's centers had adapted the Bridge to Reading Kit. The other center was using the Chapel Hill Training Outreach Program of Living Experience.

TMC was unique among grantees in using a single curriculum, the Bilingual Early Childhood Program (BECP), at all 20 of its centers. The BECP has separate modules for three-, four-, and five-year-olds, which are intended to be part of a cohesive three-year program. Only one TMC center mentioned the use of a second curriculum -- the Sesame Street Kit.

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[25] The exceptions are ECMP's two infant and toddler centers and one FFC center for three- to five-year olds which reported that it used no formal curriculum.

The center operated by MOP in Arizona used the BECP supplemented by a Goal Kit. Campesinos Unidos had integrated the BECP into an educational program developed by the grantee.

The marked diversity of curricula used is a result of the decentralization of decision-making in this area in many grantee operations. Table 24 displays the responses of head teachers who were asked, "Who decides what types of materials and what teaching methods are used in the classroom?"

TABLE 24

SOURCES OF DECISIONS ON CURRICULUM SELECTION AT MHS HOME BASE CENTERS

Source	Number of Centers	Percent of Total
Grantee education coordinator*	22	51.1%
The teacher of each class	17	39.5%
Core staff as a group	14	32.6%
Head teacher	14	32.6%
Center director	6	14.0%
Parent Advisory Council	1	2.3%

*The education coordinators mentioned in this context are specialists on grantee staffs.

Grantee specialists are the most frequently mentioned source of authority on curriculum selection. However, the response pattern also indicates that in many cases decision-making is shared by grantees and center staff and by a number of staff within individual centers. It is also notable that in only one case (an FFC center) was a Parent Advisory Council mentioned as influencing curriculum choice.

At 30 sites the curricula selected were not used strictly as written, but adapted to the children and environment at the learning center. Teachers were involved in adapting formal activity plans to their own classrooms at 31 centers. At 22 centers an education coordinator from the grantee staff was actively involved in curriculum modification. Core staff made group decisions in this area at 12 sites. Parents were cited as active participants in the adaptation process at only five sites.

Formal curricula were supplemented by materials selected or developed by teachers at 23 learning centers. A grantee education coordinator provided supplementary materials for eight centers. The staff of only one grantee neither adapted or supplemented the curricula selected for use in the classroom.

Head teachers at 35 centers stated that instructional materials and activities are explicitly modified to meet the needs of migrant children. The modifications most often cited were:

- Translation of materials into Spanish;
- Integration of culturally specific materials and activities such as dance, music and singing, and stories drawn from the folklore of black and Hispanic cultures into the formal activities plan;

- Simplification of materials (particularly vocabulary), and offering of remedial instruction where required;

The distribution of the 106 handicapped children served at home base sites by center is indicated in the following table.

TABLE 25

HANDICAPPED CHILDREN SERVED AT HOME BASE CENTERS

Number of Children	Number of Centers	Percentage of Total
None	10	23.3%
1 - 2	21	48.8
3 - 5	5	11.6
6 - 10	5	11.6
More than 10	1	2.3
Don't Know	1	2.3
TOTAL	43	100.0%

Eighteen of the 32 centers with handicapped enrollees had adapted a special curriculum for these children. The only grantee to point out a specific curriculum for handicapped children (Palatisha Project) was Campesinos Unidos. In most cases the adaptations were made by the handicap aide to suit the individual child's needs. For children with speech impairments, for example, the centers provided individualized speech therapy. At one TMC center the handicapped children were sent to a special school; in all other cases, these children were treated at the centers.

At 26 of the 32 centers mainstreaming of children with handicaps was practiced. The type of mainstreaming used at these centers is indicated in Table 26.

TABLE 26

TYPES OF MAINSTREAMING FOR HANDICAPPED CHILDREN AT HOME BASE CENTERS

Type	Number of Centers
Complete mainstreaming (a handicapped child placed in regular classroom; no supportive assistance)	13
Complete mainstreaming (a handicapped child placed in regular classroom with supportive assistance provided by a specialist)	8
Complete mainstreaming (handicapped children in classroom where the regular classroom teacher and a special education teacher cooperatively work with all children)	2
Reverse mainstreaming (normal children become part of a special education class)	0
Partial mainstreaming (handicapped children are in a special education class but go to regular classes for one or more regular classroom activities)	2
TOTAL	25*

*An SWGA center also practiced mainstreaming, but is not included here because the head teacher interviewed was uncertain of the mode of mainstreaming.

FFC centers placed handicapped children in regular classes without providing supportive services at six centers and offered supportive services for mainstreamed children at three other sites. TMC mainstreamed children without providing special services at three of its centers; it provided supportive assistance at four centers, and at one center placed handicapped children in a special class but allowed them to attend some regular activities.

e. Classroom Activities and Language Use in Classroom

1) Activities

A child enrolled at a preschool home base center is involved in a wide variety of activities on an almost daily basis. Table 27 illustrates the frequency of occurrence of 13 major learning activities at the 41 centers serving preschool children.

TABLE 27

FREQUENCY OF CLASSROOM ACTIVITY IN PRESCHOOL PROGRAMS AT HOME BASE CENTERS

ACTIVITY	Daily	Weekly	Less than Weekly	Bi-Weekly	Never
Dramatic Play(housekeeping; fire engines; airports; reproductive of community and life experiences)	36	2	2	--	1
Creative Experiences (blocks; art materials; music; literature)	38	1	1	1	--
Science Experiences(plants and animals; air; water; land; seasons; magnets)	24	10	3	2	2
Math Experiences(counting; measuring; weighing)	30	7	1	2	1
Language Development(verbalizing; dramatizing; listening)	36	4	--	--	1
Small Muscle Activity(puzzles; peg boards; art materials)	40	1	--	--	--
Large Muscle Activity (climbing; building; running)	31	3	--	--	1
Broadening Experiences (trips; visits from community workers; new and varied materials)	1	15	22	--	3
Social Skills Contacts with Children(sharing; cooperating; taking turns)	41	--	--	--	--
Social Skills Contacts with Adults	35	4	1	--	1
Problem Solving(development of manipulative and thinking processes; use of materials)	39	2	--	--	--
Learning Health and Safety Rules	28	10	2	1	--
Instruction in Health Habits	35	5	1	--	--
Instruction in Food Habits	38	2	1	--	--

The table illustrates that nearly all activities were conducted on at least a weekly basis. "Broadening experiences" are the exception to the rule. Visits to local parks and woodlands, to farms, to local facilities, such as post offices, police and fire stations, and to zoos were the "broadening experiences" cited most frequently by head teachers. On the average, between two and three field trips a month were sponsored by the preschool programs.

2) Language Use

Table 28 shows the language used by teachers and children in major classroom activity areas.

TABLE 28

LANGUAGE USE IN CLASSROOM ACTIVITIES AT PRESCHOOL CENTERS

	Language Used by Teachers for Classroom Directions			Language Used by Teachers for Classroom Instruction			Language Used by Children		
ACTIVITY	Eng	Span	Eng & Span	Eng	Span	Eng & Span	Eng	Span	Eng & Span
Dramatic Play	10	9	22	10	9	22	10	12	19
Creative Experiences	10	10	21	10	8	25	10	12	19
Science Experiences	10	11	20	10	11	20	10	14	17
Mathematics Concepts	10	8	23	10	7	24	10	10	21
Furthering Language Development	11	7	23	11	8	22	10	11	20
Furthering Small Muscle Activity	10	10	21	10	10	21	10	13	18
Furthering Large Muscle Activity	10	8	23	10	8	23	10	11	20
Broadening Experiences	10	8	23	10	8	23	10	10	21
Furthering Social Skills Contacts with Children	10	10	21	10	10	21	10	13	18
Furthering Social Skills Contact with Adults	10	10	21	10	10	21	10	12	19
Problem Solving	10	9	22	10	9	22	10	12	19
Learning Health and Safety Rules	10	9	22	10	9	22	10	13	18
Good Health Habits	10	8	23	10	8	23	10	12	19
Good Food Habits	10	8	25	10	8	25	10	12	19

It is apparent from the table that there is little variation in language use, either by the teacher or the child, from activity to activity. These data show ten of the 41 centers using only English in their instructional programs. Another group of from seven to 11 centers use Spanish in the classroom, while bilingual instruction is provided at 20 to 25 programs. In two or three programs where teachers are using English, children continued to speak Spanish in the classroom.

Thirty of the 41 preschool centers reported that a regular schedule was followed for the development of both English and Spanish; twenty-seven reported that they followed this schedule on a daily basis. Language dominance measures were used as a basis for grouping children in language instruction classes at only 11 centers.

3) Other Indicators of Multiculturalism

All but two of the 43 centers surveyed reported that they integrated stories, music, and games related to the migrant child's culture into their classroom activities. Thirty-one programs did so daily, eight at least once a week, and two less often than this. The two centers that did not follow this practice were operated by TMC and FFC.

All but three centers also reported serving foods associated with the culture of migrant children. Thirteen did so every day, four more than once a week, 15 on a weekly basis, and eight less often.

Cultural events and holidays specifically related to the cultural background of migrants were celebrated at 37 sites. Five TMC sites and one of SWGA's two centers did not integrate celebrations of culturally specific events and holidays into their classroom activities.

f. Procedures Followed by Classroom Teachers

A daily activities schedule was posted and followed in each classroom in all but one center. The exception was an infant and toddler program operated by ECMP.

Education objectives were established for each child at 35 sites. The exceptions were four centers operated by FFC, one by TMC, the program operated by MOP, and the two ECMP infant and toddler centers. Teachers were required to turn in written lesson plans defining educational objectives and describing an activities plan to meet these objectives at 36 centers. Procedures were established for the regular monitoring of the progress of children in relation to established objectives at 35 of them.

Tests that are part of a curriculum kit were used to monitor progress at 15 centers. Fourteen used other standardized tests, and nine centers used locally designed assessment methods.

All preschool centers reported that parents were kept informed of the progress of their children during the school year. Table 29 shows the means of communicating this information most frequently mentioned by head teachers.

TABLE 29

METHODS OF INFORMING PARENTS OF CHILD'S PROGRESS AT HOME BASE CENTERS

Method	Number of Centers	Percentage of All Centers
Home visits by staff	36	83.7%
Conferences at center	21	48.8%
Written reports sent to parents	20	46.5%
Telephone calls to parents	13	30.2%

Teachers did not allow children to take toys and instructional materials home with them at 34 of the 43 centers. This restriction did not extend to things constructed by children as part of their classroom activities. The reason given for this policy was fear that toys and instructional materials, which were often in short supply, would be broken or lost. Even at the five FFC and TMC sites where children were allowed to take materials home, this practice was limited. However, on a number of occasions it was mentioned that children were sometimes allowed to keep a particular favorite toy at the close of the school session.

g. Parent Involvement in Classroom Activities

Parents of children enrolled at home base programs are involved in the centers' activities in a number of ways. Table 30 shows the types and extent of parent involvement, according to head teachers, in home base center classrooms.

TABLE 30

PARENT INVOLVEMENT IN CLASSROOM ACTIVITIES AT HOME BASE PROGRAMS*

Type of Involvement	Number of Parents
Sending materials from home	428
Serving as volunteers	145
Employed as teachers or as teacher's aides	34
Paid as other than teachers or teacher's aides	15
Other	80

*Parents could have been involved in programs through more than one method.

Forty-nine parents held paid staff positions in 18 home base programs. Twenty-four centers that had no parents working as teachers or teacher's aides belonged to the two largest grantees, FFC and TMC. Two more were ECMP centers. Seven FFC centers and nine TMC centers reported no parents contributed to the program by sending something from home. The other four centers that lacked this dimension of parent participation were ECMP centers.

During the month preceding the survey, head teachers reported that:

- 242 parents actively participated in the instructional program and
- 121 parents came to the center to observe classroom activities.

These figures suggest that approximately ten parents came each month to observe or participate in learning activities at a typical center. Four TMC and one SWGA center reported more than 15 parents actively participated in their programs in the previous month. Table 31 illustrates the response pattern of head teachers asked to describe the techniques used to get parents to participate in classroom activities.

TABLE 31

METHODS OF SECURING PARENT PARTICIPATION IN CLASSROOM ACTIVITIES

Methods	Centers	Percentage of All Centers
Home visits	29	67.4%
Parent/staff meetings	28	65.1%
Phone calls	27	62.8%
Letters	20	46.5%
Newsletters	18	41.9%
Training sessions	5	11.6%
Other	4	9.3%

All of the 43 head teachers interviewed reported that they met individually with parents to discuss the center's instruction program. On the average, head teachers had individual meetings with 39 parents during the school year.

At 39 centers a member of the teaching staff met with one or both parents of all enrollees at least once a month. One center conducted bimonthly meetings; one followed a policy of holding at least two meetings during the school year; and one center stated that teachers seldom met with parents.

Meetings took place mainly at the centers in 25 sites. Sixteen centers reported that parent-teacher meetings occurred both at the center and the homes of parents. Respondents at only two centers reported that teachers generally went to the home of parents to discuss the instructional program and the progress of their children.

At all but four centers it was stated that parents were always contacted if a child missed three or more days of school to determine the reason. Three sites reported that this procedure is sometimes followed, and one reported that contacts are made after a child misses five days.

Sixty percent of the centers reported giving learning materials to parents designed for use at home by parents and their children. In 15, materials were written in both English and Spanish. Eight sent only English learning materials; three sent materials in Spanish only. No learning materials designed for parent-child use at home were given to parents at ten TMC sites, four FFC sites, and three of the five programs operated by ECMP. Bus drivers were the most common means of sending the materials. The children themselves ranked second. Only six centers reported that a staff member personally took the materials into the homes of parents.

3. Health Services

a. Profile of Staff Members Responsible for Service Delivery

Center level responsibility for health services delivery was exercised by persons in various staff positions at the 43 centers surveyed. The following table shows the distribution of staff positions for the individuals responsible, on a day-to-day basis, for health services at the centers.

TABLE 32

POSITIONS HELD BY RESPONDENTS TO THE HEALTH MODULE

Position	Number of Centers
Health aide	21
Center director	9
Health coordinator	4
Handicap aide	4
Nurse	3
Social services worker	1
Head teacher	1

Persons who can be regarded as health administrators (including handicap aides) exercised health service delivery responsibilities at three out of four centers. Twenty-five of these 32 individuals were paraprofessionals; only the four health coordinators and three nurses working at seven centers can be classified as health professionals. Health aides represented the largest group among the paraprofessionals, constituting 48 percent of all respondents. Seventeen of the 21 health aides worked at TMC centers.

Among the eleven non-specialists exercising day-to-day responsibility for health services, nine were center directors working at Florida Farmworker Council program sites. A social services worker performed this function at one FFC site, and a head teacher was in charge of health services at one TMC center.

The person with primary responsibility for health services was almost always assisted by one or more staff. Teacher's aides and social services workers most commonly provided this assistance. In addition, the center staff responsible for health-related activities are often supervised and assisted by part-time or voluntary county or area nurses. Grantee level health coordinators also assisted and supported site level staff in the performance of their duties.

Among the 43 persons working as health administrators[26] at each site, 91 percent were women. Hispanics, mainly Mexican-Americans, comprised 58 percent of this group. The next largest ethnic group represented here was blacks, who constituted 28 percent of the total.

English was the language of 56 percent of this group, and Spanish was the native tongue of 44 percent. All Spanish-speaking health providers spoke English as a second language. Only six persons whose first language was English said they spoke Spanish as a second language.

The mean age of health administrators was 31 years. Eleven, including nine health aides working at TMC sites, were less than 20 years old.

The majority of health administrators (76.7 percent) had either a high school diploma or a general education diploma (GED) as their most advanced degree. Another 14 percent had attained either a two-year or four-year college degree. Five persons in this group held nursing credentials (two with two-year college degrees, one L.P.N., one L.V.N., and one R.N.).

Health administrators had held their current jobs for an average of 31 months. Approximately one half of these staff, however, had served in their current positions at the centers for six months or less, indicating a high turnover rate. Three health administrators from FFC had held their positions longer than six years and three others from FFC had served for over four years.

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[26] Hereafter, health administrator will be used to refer to the 43 persons performing the duties associated with this position, regardless of differences in job titles.

Only 19 percent of the health administrators had experience at other Migrant Head Start centers. The persons who had worked at other Migrant Head Start centers averaged approximately five years there. This group was composed exclusively of health administrators from centers operated by the Florida Farmworkers Council and the Texas Migrant Council.

Forty percent of the health administrators reported some other preschool experience. This group averaged a little less than two years of this type of experience. All grantees were represented.

Slightly less than one quarter of the 43 health administrators indicated that they were taking courses related to their program responsibilities. These persons came from all grantees except Southwest Georgia Community Action Council.

Overall, 15 health administrators had certificates or special credentials related to their Migrant Head Start work. Three of these credentials were CDAs, held by two center directors and one head teacher. Three were State certifications, one of which was held by a center director, and nine others included First Aid training certificates, handicapped and child health certificates, and one Emergency Medical Technology certificate.

Eighteen health administrators were working on special credentials or certifications that related to their Migrant Head Start work. Eight CDA and one Bilingual/Bicultural CDA certificates, two R.N.'s, and two early childhood development certificates were being studied for. Five center directors were studying for their CDAs.

b. Other Resources Used for the Health Component

As mentioned above, health administrators are often assisted by other staff members at the centers in delivering health services to the children. At Texas Migrant Council centers, for example, 21 additional staff members, or approximately one extra person for each of the 20 TMC centers, assisted health administrators. The other grantees reported similar levels of assistance.

Among the staff helping health administrators, teacher's aides were mentioned at 30.2 percent of the centers and social services workers at 23.3 percent. Other staff providing assistance included center directors, head teachers, and teachers.

Migrant Head Start centers received health services support from a number of sources. Qualified professionals or diagnostic teams from hospitals, clinics or other public and private agencies provided health services support at 86 percent of the home base centers. All centers of the East Coast Migrant Project, Migrant Opportunities, and Campesinos Unidos made use of this type of health services support. All but one of Florida Farmworkers' 14 programs, one of the two Southwest Georgia programs and 16 of the Texas Migrant Council programs made use of professionals or diagnostic teams from nearby private and public agencies.

Private physicians and dentists were the second major source of health services support used by MHS centers. Nearly two thirds of all centers made use of their services, including all CUI, SWGA, MOP, and ECMP centers.

MHS diagnostic teams were the third major source of health-related support for programs surveyed. These teams provided health services support at 10 TMC centers, and at the centers operated in Arizona and California by MOP and CUI.

The following table provides a breakdown by grantee of sources of health-related support for the 43 centers.

TABLE 33

HEALTH SERVICES SUPPORT RECEIVED
BY HOME BASE PROGRAMS*

	FFC (N=14)		ECMP (N=5)		SWGA (N=2)		TMC (N=20)		MOP (N=1)		CUI (N=1)		Total (N=43)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Private physicians/ dentists	4	30.8	5	100.0	2	100.0	14	70.0	1	100.0	1	100.0	27	62.8
MHS Diagnostic Team	-	-	-	-	-	-	10	50.0	1	100.0	1	100.0	12	27.9
Professionals from public and private health-related agencies	13	92.9	5	100.0	1	50.0	16	80.0	1	100.0	1	100.0	37	86.0
No support received	1	7.1	-	-	-	-	-	-	-	-	-	-	1	2.3

*More than one response can apply.

c. Training Provided for Staff Responsible for Delivery of Health Services

In an effort to have qualified personnel care for the health needs of Migrant Head Start children, center staff have been provided with a variety of health-oriented training.

Training at most of the centers was quite diversified and most of a center's staff, not just the health administrator, participated in several of the health area sessions.

Both pre- and inservice health training was provided to Migrant Opportunities staff by three universities in Arizona. The grantee staff provided no training, relying instead on these outside sources. Both preservice and inservice training focused on the special needs of the handicapped, nutrition, treatment of developmental problems, screening assessments, and safety. A total of 56 hours were scheduled for pre- and inservice health training.

One of the two Southwest Georgia centers had preservice health training. This preservice training was conducted by grantee staff and focused on child abuse, nutritional health and the education of handicapped children. All staff at the center participated in preservice health training that totaled eight hours.

Inservice health training at both Southwest Georgia centers was extensive. A total of 84 hours of inservice health training was provided at the centers. Areas of inservice health training were nutritional health, special health needs assessments, general physical and mental health and the identification of child abuse. All staff from the centers participated in these inservice training sessions. A health professional from one of the centers assisted grantee personnel in providing pre- and inservice training.

Sixteen of the 20 TMC centers were provided with preservice health training. Most of the training was provided by the central and regional offices of TMC. The health areas covered were diverse, including health problems of the handicapped, health assessments and screenings, nutrition, first aid, and child abuse.

Inservice health training at 17 TMC sites was provided by grantee specialists, center directors, and head teachers. Outside agencies were also utilized including the Red Cross, Southwest Child Educational Development Laboratory in Austin, and appropriate State agencies.

Training covered a wide range of health and health-related fields, such as mental health/mental retardation, general health education, first aid and nutrition. Health specialists from the Portage Project of the University of Wisconsin assisted in training staff in the area of developmental assessments and teaching handicapped enrollees about their own health problems. The 17 centers provided inservice health training averaging approximately 50 hours.

FFC used its own central office staff as well as the staff of its MHS centers to provide preservice and inservice health training. Approximately 20 hours of preservice health training was provided by FFC for staff at 11 of its centers. The center director, all health-related personnel, and outreach staff received health training. In general, the health training program consisted of nutritional education, first aid, psychological and physical screening, child abuse, safety, and the prevention of common diseases and ailments.

Inservice training was also provided by FFC at 11 of its centers. This training focused on identifying the medical and nutritional needs of migrant children, the special needs of the handicapped, and indications of child abuse. On the average, 15 hours of inservice health training were provided at the centers. Specialists from the Mailman Center for Health at the University of Miami also were used to provide inservice training at three local centers. These specialists focused their training on procedures to identify children with specific developmental problems, such as dyslexia and hearing and speech impairments.

At each of the five ECMP centers, health administrators participated in an average of 16 hours of preservice training courses taught during a three-day session. At four centers health administrators were assisted by aides who also received training. Areas of preservice training included general health education, all types of screening, child abuse, and safety.

Inservice training focused upon specialized health education for the handicapped, first aid, and nutritional aspects of health. A total of 84 hours of inservice health training was provided at all five centers. The inservice training provided by ECMP was coordinated by a grantee level health specialist.

Health training for the Campesinos Unidos grantee was provided by the Westinghouse Corporation, the California State Department of Children's Nutrition and the Imperial Valley Community College. All three sources provided a total of 54 hours of preservice and inservice training. The health areas covered during the preservice training focused on nutritional health, medical education, and dental health. All staff participated in the preservice health training, with the center director, head teacher, and health administrator participating in an additional 24 hours of training. Their additional training consisted of nutritional health, health education, and handicapped children's health problems.

Inservice health training at CUI totaled nine hours. Inservice training consisted of nutritional health education and the identification of undiagnosed handicaps. Campesinos Unidos and Migrant Opportunities are the only grantees which did not themselves provide inservice training. Also, CUI was the only grantee which used outside sources exclusively both in preservice and inservice health training.

d. Service Delivery: Screening, Referral, and Follow-Up Services

One goal of the health services component of Migrant Head Start programs is to provide complete medical, dental, and developmental assessments for all children enrolled in the programs. These assessments are to identify children who require diagnosis and referrals for specific treatment.

The following data were collected during site visits from March 26 through May 12, 1979.

1) Medical Screening, Referral, and Follow-Up Services

At least some children at all 43 centers visited had received medical screenings. All enrollees had been screened at 29 (67 percent) of the centers. Screenings had been scheduled at nine of the 14 centers with unscreened enrollees. Three TMC centers had not scheduled screenings and there was no response to this question at two centers (SWGA and FFC).

Twenty-one centers (49 percent) performed medical screenings at the center while 17 (39.5 percent) referred children to nearby medical facilities. Medical screenings were performed at both locations at the remaining five centers.

Twenty-nine centers (67.4 percent) reported that all of their children had received medical screenings to identify specific health problems. All of the remaining centers had screened at least some of their children. Of the children screened, 372 were diagnosed as having medical problems. At four TMC and four FFC centers, no children were identified as requiring treatment or referral.

In general, children referred for medical treatment by a MHS center received treatment. This was true for 92 percent of all children referred. The exception is the Florida Farmworkers Council program where only 24 of the 50 children referred for treatment actually received it. The following table provides a breakdown by grantee of referrals and treatment.

TABLE 34

CHILDREN REFERRED FOR AND RECEIVING MEDICAL TREATMENT

Grantee	Children Referred	Children Treated	Percentage Treated
FFC	50	24	48.0%
ECMP	135	135	100.0%
SWGA	17	17	100.0%
TMC	147	145	98.6%
MOP	15	15	100.0%
CUI	8	7	87.5%
TOTAL	372	343	92.2%

2) Dental Examinations, Referrals, and Follow-Up Services

Twenty-five centers provided 1,286 children with dental examinations. Eleven TMC centers, six FFC centers, and one SWGA center had not provided dental examinations for all of their children. Of the 18 centers where some children had not yet been examined, 11 had scheduled these children for dental examinations.

Eleven of the centers which had completed dental examinations did so at the center; nine others had the examinations performed at nearby medical facilities. One center used another MHS center, and three centers completed some dental examinations at the center and some at a nearby medical facility.

Eighty-six percent of the home base centers identified children in need of dental treatment. Of these 37 centers, 33 had referred 503 children for treatment. As Table 35 shows, eighty-five percent of these referrals were treated.

TABLE 35

CHILDREN REFERRED FOR AND RECEIVING DENTAL TREATMENT

Grantee	Children Referred	Children Treated	Percentage Treated
FFC	107	65	60.7%
ECMP	41	41	100.0%
SWGA	85	85	100.0%
TMC	233	203	87.1%
MOP	37	37	100.0%
CUI	DK*	DK	--
TOTAL	503	431	85.0%

*The respondent exercising responsibility for health service delivery at CUI was uncertain of the number of children referred for and receiving treatment. Records indicated, however, that seven children had received a dental exam.

Three grantees -- East Coast, Southwest Georgia, and Migrant Opportunities -- which referred a total of 163 children for further dental treatment, provided treatment for all children referred. These children account for 32.4 percent of all children referred for further dental treatment. Eighty-seven percent of TMC children and 60 percent of FFC children who had been referred had actually received treatment.

3) Developmental Screening/Assessment

Developmental screening and assessment was performed for all children at 31 centers. Ten centers which had not provided screening for all children had scheduled screenings. One FFC center had not scheduled the unscreened children for developmental assessment and the health provider at one TMC center was uncertain on this question.

Children were diagnosed as having development problems at 19 centers. Fifteen of these had referred children for further treatment. Table 36 provides a breakdown by grantee of referrals and treatment.

TABLE 36

CHILDREN REFERRED FOR AND RECEIVING DEVELOPMENTAL TREATMENT

Grantee	Children Referred	Children Treated	Percentage Treated
FFC	20	5	25.0%
ECMP	15	15	100.0%
SWGA	2	2	100.0%
TMC	12	5	41.6%
MOP	7	7	100.0%
CUI	DK*	DK	--
TOTAL	56	34	60.0%

*The CUI health administrator was uncertain of the number of referrals at the Brawley center, and whether any referrals were treated. According to center records, however, seven children had received a developmental screening.

Only two percent of all home base program enrollees were found to have developmental problems which required referrals and treatment. Sixty percent of the 56 referrals received treatment. All of the 24 children referred by ECMP, SWGA, and MOP were treated. TMC and FFC showed a low frequency of children receiving treatment among those referred. Only 41.6 percent of TMC referrals and 25.0 percent of FFC referrals had been treated. Children not receiving treatment account for 57.1 percent of the total number of children referred by centers operated by these two grantees.

At centers where some enrollees had not received medical, dental, or developmental screenings, health providers were asked for explanations. The most frequent response was that unscreened children were new arrivals and consequently there had not been enough time to schedule and provide the services. Most respondents added that new enrollees would get these services once the center staff had time to perform the services, or when appointments could be made at nearby medical facilities. Lack of funds for performing assessments was also cited. One Southwest Georgia center stated that no IMPD funds were available to conduct these assessments. One center cited a lack of support from the grantee, while another stated that a registered nurse was unavailable to provide services.

e. Service Delivery: Immunizations

Providing all children enrolled in the program with the proper immunizations is another goal of the health component at MHS home base programs. Children under three years of age should be up to date with their immunization schedules, while children three years and older should have completed the immunizations.

The following table shows the status of immunizations for DPT, polio, measles, rubella, and mumps received by children enrolled in the 43 home base sites obtained at the time of our visits.

TABLE 37

CHILDREN WITH UP-TO-DATE OR COMPLETED IMMUNIZATIONS

	FFC		ECMP		SWGA		TMC		MOP		CUI		Total	
	(N=589)		(N=250)		(N=115)		(N=1492)		(N=110)		(N=38)		(N=2594)	
Immunizations	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
DPT	480	81.5	244	97.6	115	100.0	1095	73.3	DK*		38	100.0	2058	79.3
Polio	480	81.5	244	97.6	115	100.0	1140	76.4	DK		38	100.0	2103	81.0
Measles	482	81.6	244	97.6	115	100.0	1391	93.2	DK		38	100.0	2356	90.8
Rubella	482	81.6	244	97.6	115	100.0	1383	92.6	DK		38	100.0	2348	91.4**
Mumps	482	81.6	244	97.6	115	100.0	1320	88.4	DK		38	100.0	2285	88.0

*The Migrant Opportunities health administrator was uncertain of the numbers of children receiving immunizations.

**Based on 2568 since the records of 26 children indicated that they had had rubella in the past.

f. Health Record Transfer

The timely transfer of health records of children who have been enrolled in previous programs is important for effective treatment, immunization, and avoiding redundancy in screening and diagnosis. Table 38 shows the time usually required to receive health records of new enrollees with previous Head Start experience.

TABLE 38

TIME REQUIRED TO RECEIVE HEALTH RECORDS OF NEW ENROLLEES FROM OTHER HEAD START PROGRAMS

Time Required	FFC	ECMP	SWGA	TMC	MOP	CUI	Total	Percent
Less than two weeks	4	2	1	11	0	1	19	44.2%
2 - 4 weeks	1	0	0	4	0	0	5	11.6
More than 4 weeks	1	0	0	0	0	0	1	2.3
Records usually not transferred	6	2	1	2	1	0	12	27.9
Don't know	2	1	0	3	0	0	6	14.0
TOTAL	14	5	2	20	1	1	43	100.0%

While records arrived at the centers in less than two weeks at 44 percent of the centers visited, respondents at 28 percent of the centers said that records of previous enrollments were usually not transferred.

Records transfer from non-Head Start programs to the MHS programs surveyed was only slightly less effective than transfers from other Head Start programs. Records from non-Head Start programs arrived within two weeks at 33 percent of the centers surveyed. Respondents did not know the length of time required for records transfers of this kind at 39.5 percent of the centers. Nine percent of respondents said transfers took from two to four weeks, and 19 percent said health records were usually not transferred at all.

Reasons why records were not transferred from previous Head Start and non-Head Start programs included:

- Parents could not recall where children had been previously enrolled;

- No records were kept at the previous program;
- Records were requested but not sent; and
- Records were not requested by their centers.

A major factor complicating and impeding effective transfer of records is that migrant parents sometimes abruptly leave the site area for a new location without informing the center staff of their departure or the family's destination. Quite often parents do not know their exact destination.

The Migrant Student Record Transfer System (MSRTS) also is affected by the unannounced departure of migrant families. When a family leaves without specifying a destination, an updated MSRTS record will not be at a destination center upon the child's enrollment. The destination center may request the child's MSRTS records, a process which can take up to two or three weeks. By the time records do arrive, the migrant family may already be on its way to the next area, thereby further complicating the process of transferring records.

One hundred and two children at home base centers were enrolled in Medicaid. Medicaid's Early Periodic Screening, Diagnosis and Treatment Program paid for the health services used by 86 percent of these children. Below is a table showing the percentage of eligible children by grantee who received EPSDT/Medicaid benefits.

TABLE 39

CHILDREN ENROLLED IN MEDICAID WHOSE HEALTH FEES ARE PAID BY EPSDT/MEDICAID

Grantee	Children Enrolled In Medicaid	Children Receiving Health Services Paid by EPSDT/Medicaid	Percentage
FFC	52	48	92.3%
ECMP	12	3	25.0%
SWGA	19	19	100.0%
TMC	19	16	84.2%
MOP	-	-	-
CUI	DK	DK	-

g. Parent Involvement in Health Services Delivery

1) Introduction to the Program and Parental Consent

Parent involvement efforts in the health component at MHS home base centers begin with the effort to inform parents about health services offered by the center and the health care to be received by their child. According to health administrators, all parents at 39 centers received explanations of the health program when their child was enrolled at the center. Respondents at the other four centers reported that most parents received information about the health program at that time.

Every center except one stated that parental consent was always obtained for health screening and treatment. The exception, a TMC center, said parental consent was generally obtained for health services.

2) Health Education

Health education programs directed at parents operated at 35 centers. Centers generally used one or more methods to educate parents about health. Table 40 shows the frequency of use for the most common methods.

TABLE 40

METHODS USED TO EDUCATE PARENTS IN HEALTH PRACTICES

Methods	Percentage of All Centers
Lectures and study groups	60.5%
Visits to parents' homes	51.0%
Use of printed materials	49.0%
Slide and film presentations	9.3%

Twenty-two centers reported holding education meetings for parents at least once during the program session. Three other centers did not know how many meetings had been held for parents, while 18 centers had held no meetings of this kind. Twenty centers reported holding health education meetings for parents during the month prior to the time health respondents were interviewed.

3) Health Services Advisory Committee

Health Services Advisory Committees (HSACs) are formed at MHS centers in order to incorporate ideas from parents into the policies and procedures that shape the health component at these centers. Only 13 MHS home base centers had active HSACs. Twenty-five respondents said their centers did not have an HSAC; five did not know.

4. Nutrition

a. Profile of Respondents to the Nutrition Module

The nutrition programs at Migrant Head Start sites are generally supervised by cooks working at these sites. (See Table 41.) The only exceptions occurred at one Texas Migrant Council site and two Florida Farmworkers Council sites. At the TMC site the center director had temporarily assumed the responsibilities because the center cook had been dismissed. The duties of food manager[27] at the two FFC sites were performed by a nutritionist and a teacher's aide.

TABLE 41

POSITIONS HELD BY RESPONDENTS TO THE NUTRITION MODULE

Position	Number of Centers	Percentage of Centers
Center Director	1	2.3%
Teacher's Aide	1	2.3
Nutritionist	1	2.3
Cook	40	93.0
TOTAL	43	100.0%

All 43 centers employed a female food manager. Their mean age was 51 years, making them the oldest group of Migrant Head Start staff members.

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[27] Hereafter, food manager will refer to the 43 persons performing the duties associated with this position, regardless of differences in job titles.

Approximately one half of these women were Hispanic of Mexican descent. Nineteen of the 23 Hispanic food managers worked at TMC sites. Blacks comprised the second largest ethnic group, accounting for 14 positions.

Slightly more than 50 percent of the food managers spoke English as a first language. The remaining 21 persons said that Spanish was their primary language. All but one of the latter group were bilingual, while only three food managers whose primary language was English also spoke Spanish.

The typical center food manager had an eighth-grade education. Ten had completed a secondary education and the center director acting as a food manager had received a two-year college degree.

The food managers had an average of almost four years' experience at their current jobs. The food managers at 13 centers had worked there less than 12 months. However, 15 food managers had served at their present job for over five years. Notably, three of these food managers had held their present positions for the ten years that Migrant Head Start has existed.

In general, members of this group have retained the same jobs throughout their Migrant Head Start employment. Only seven had prior work experience at another Migrant Head Start center. Five of these food managers worked at TMC centers, and one each at an ECMP and FFC site. The length of their employment at other MHS programs ranged from six months to over six years.

In addition, 14 food managers had accumulated preschool experience outside of Migrant Head Start. Once again, the majority were in TMC (seven) and FFC (five) programs. The overall staff average was one and one half years of prior preschool experience.

Few food managers were taking courses which were related to their work. Only 14 percent were enrolled in some type of work-related course.

Similarly, only a small fraction of the group (13.8 percent) had been awarded special credentials or certification. Food managers at three FFC sites had received certificates for the successful completion of grantee workshops on nutrition and one had been certified in first aid.

Food managers in two TMC centers had received special certificates. One had both a nutrition and a Palatisha Certificate. The second had been awarded a certificate for attending a one-and-a-half-day handicapped workshop.

Three food managers at centers operated by the remaining grantees were actively working towards attaining credentials and/or certificates.

The greater age and lack of formal education of most of the food managers interviewed may partially explain the relatively small percentage who had either completed or were working towards special certification. Further, many of these people had been institutional cooks for many years before they started working for Migrant Head Start, and felt no need to supplement this experience with formal training.

b. Service Resources

All but two of the 43 centers prepared their food on the site. A contract service was used by one FFC center while another utilized the kitchen facilities of a former Head Start center. In the latter case, the center cook prepared food at facilities a short distance from the center and the food was then transported to the center.

At least 20 centers (46.5 percent) received USDA Child Care Food Program reimbursement. However, 16 respondents did not know whether or not their center received reimbursement.[28]

TABLE 42
HOME BASE CENTERS RECEIVING USDA REIMBURSEMENT

Grantee	Number of Centers Reimbursed	Percentage of Centers
FFC	9	64.3%
ECMP	4	80.0%
SWGA	1	50,0%
TMC	6	30.0%
MOP	-	-
CUI	-	-
TOTAL	20	46.5%

A minimum of seven centers were not currently receiving reimbursements from the Child Care Food Program. One did not know of the existence of the program. The remainder of this group did not provide an account of why their centers did not obtain funding.

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[28] Forty of the respondents were center cooks who did not have fiscal management responsibility.

c. Training for Delivery of Services

Policies and procedures formulated at the grantee and Federal level are often communicated through pre- and inservice training. Those pertaining to the nutrition component are no exception. Preservice training was provided to respondents and other staff members at all sites except the CUI center. (See Table 43.)

TABLE 43

PRESERVICE TRAINING RECEIVED BY FOOD MANAGERS AT HOME BASE CENTERS

Type	Number of Centers	Percentage of Total
Child nutrition	28	65.1%
Food purchasing	28	65.1%
Sanitation	28	65.1%
Food preparation and storage	27	62.7%
Menu planning	24	55.8%
Other	1	2.3%

As Table 43 demonstrates, the areas of nutrition, food purchasing, and sanitation received the most attention, followed closely by menu planning and food preparation and storage.

A somewhat smaller proportion of centers provided inservice training programs. (See Table 44.)

TABLE 44

TYPE OF INSERVICE TRAINING RECEIVED BY FOOD MANAGERS AT HOME BASE CENTERS

Type	Number of Centers	Percentage of Total
Food purchasing	25	58.1%
Food preparation and storage	25	58.1%
Sanitation	24	55.8%
Child nutrition	22	51.1%
Menu planning	21	48.8%
Other	2	4.6%

Most of the centers that provided preservice programs continued training during the school year. The CUI center, which lacked any preservice training, provided inservice training in all the above categories.

Thirteen centers received nutrition training through outside agencies. The assistance to the centers came from five primary sources:

- County health departments,
- Universities,
- Private clinics, and
- Other private agencies.

Centers administered by the East Coast Migrant Head Start Project and the Southwest Georgia Community Action Council received no training assistance through outside agencies.

Food managers at 12 centers indicated that additional training assistance was needed. They specified the areas of 1) food preparation, 2) nutrition education, 3) staff training, and 4) creativity in menu planning.

d. Service Delivery

All home base centers provided the children with both breakfast and lunch. In addition, an afternoon snack was given to the children at every center except one TMC site. The two SWGA centers and one TMC center also supplied a morning snack. The morning snack, however, was not favored by many of the food managers because they felt it spoiled the children's appetite for lunch.

The allotted time for meals ranged from under a half-hour to over an hour. At 81.4 percent of the centers, meals lasted between 30 and 45 minutes.

Food managers at 39 centers indicated that children preferred particular foods. In general, the foods they preferred reflected their cultural backgrounds. This was most apparent among the TMC centers where most of the children enjoyed Mexican foods such as rice and beans, tacos, and burritos. Many of the Hispanic children also liked hot dogs, hamburgers, and french fries.

At centers with children of diverse ethnic backgrounds, the children favored more traditional American foods. These included hot dogs, spaghetti, and baked beans. Children throughout the programs liked various types of chicken dishes.

Thirty-four food managers listed types of food which children did not seem to like. The centers with a high proportion of Hispanic children reported that dishes prepared with tuna, cheese or macaroni were especially disliked. Children at several sites refused to eat liver. Many also did not enjoy eating vegetables. Broccoli, spinach, and greens were often mentioned.

Children's preferences often depended upon their previous exposure to those foods. Ideally, centers should present activities focusing on greater enjoyment and understanding of a variety of foods. Thirty-three centers provided such activities. Of those that did, 18 centers used field trips, 11 planted gardens, 14 had menu planning and food preparation activities, and 12 had tasting parties. Seven centers utilized other activities to stimulate the children's interest and enjoyment of food. These included:

- Games (FFC),
- Tours of kitchen facilities (TMC),
- Visits by food service professionals (TMC),
- Food exhibitions (FFC), and
- Food as art (ECMP).

e. Mealtime Activities

Mealtimes are an extension of the children's education. Children at 34 centers used this time to interact with one another. Almost an identical number of centers encouraged mealtime conversations which enrich the child's understanding of food and nutrition. Three sites said that conversations were not encouraged.

All but two centers reported that foods were served that reflect the migrant child's culture. How often they were served varied; 36 centers prepared foods of this type at least weekly. (See Table 45.)

TABLE 45

FREQUENCY OF SERVING OF FOODS REFLECTING THE MIGRANT CHILD'S CULTURE

Frequency	Number of Centers	Percentage of Centers
Daily	5	11.6%
Weekly	31	72.0
Less than weekly	5	11.6
Seldom or never	1	2.3
No response	1	2.3
TOTAL	43	100.0%

When the staff joins the children at meals, eating the same foods, they can provide more than just supervision. They are able to set examples which augment the children's understanding of nutrition, and serve as models of good eating habits. Most staff members at every center ate with the children on a regular basis.

Children from all the centers participated in various mealtime activities. Children assisted in table-setting and clean-up activities at 38 centers. Children at 16 centers helped serve food, and at six sites they were involved in food preparation.

To ensure that the children received balanced meals, every center used some form of menu planning. The Head Start meal pattern was followed by 25 centers, 12 of which were TMC sites. A USDA plan was used at two programs and parents chose the menu at two others. Menus at six centers were determined by a combination of the Head Start and USDA plan, plus parental input. Other centers either planned meals themselves or used grantee suggestions.

f. Parent Involvement

Migrant Head Start parents are encouraged to participate in the planning of menus. Parents at 19 of the 40 centers where data were available had influence over the types of foods prepared. Parents were involved in menu decisions in over 50 percent of the FFC, SWGA, and CUI sites.

When food managers select a menu, they must consider those children with special dietary needs. At 23 sites parents were asked by center staff to identify special dietary needs of their children. Seventeen centers did not inquire about the dietary requirements of the children who were enrolled. Respondents at three centers did not answer the question.

Of the 23 centers that did survey the parents, 18 (77 percent) provided individualized plans to compensate for special conditions identified by parents. The most widely used procedure was substitution. This usually occurred when a child was allergic to particular foods. Appropriate substitutes replaced essential foods such as orange juice and milk. One FFC site consulted a doctor and one TMC site conferred with a migrant clinic before altering a child's diet.

Findings indicate that over the course of a month parents ate at least one meal with their children at 74 percent of the 43 centers. The MOP and SWGA grantees had parents join their children for meals at each of their centers. At TMC sites, over 75 percent of the parents had joined their children for a meal.

Many migrant families qualify for food supplements under the Women, Infants, and Children Supplemental Food Program (WIC). Only five respondents, however, were able to identify how many families were receiving aid from WIC. Three indicated that no families were receiving benefits, while two (one each from FFC and TMC) identified a total of 37 families receiving aid from WIC. The other 38 did not know.

Nutritional education is one of the most direct methods of involving parents in food planning. Almost one half of the home base centers indicated that they provide nutrition education for parents, with at least one center represented from each grantee except CUI. Classes to teach parents about the nutritional value of foods were offered at ten centers, while individual counseling of parents and sending pamphlets which explain special nutritional problems to parents were each practiced at four centers. Three quarters of the centers providing nutritional education did so on at least a monthly basis.

5. Social Services

a. Profile of Staff Members Responsible for Social Services

Responsibility for providing the services associated with the social services component at the 43 Migrant Head Start home base centers is usually exercised either by a social service specialist or the center director. As Table 46 demonstrates, social service specialists were accountable for these duties at 17 centers (39.5 percent) and center directors at 15 centers (34.9 percent).

TABLE 46

POSITIONS HELD BY RESPONDENTS TO THE SOCIAL SERVICES MODULE

Position	Number of Centers	Percentage of Total
Social Service Specialist	17	39.5%
Center Director	15	34.9
Handicap Aide	4	9.3
Teacher's Aide	3	7.0
Head Teacher	2	4.7
Teacher	1	2.3
Health Aide	1	2.3
TOTAL	43	100.0%

Other staff responsible for this element of service delivery included head teachers, teachers, teacher's aides, health aides, and handicap aides.

Social service providers[29] at MHS home base centers are comparatively young. Their average age was 33 years. More than 50 percent were under 31 years of age. Only one respondent was over 50 years old.

Eighty-four percent of the 43 social service providers were women. Five centers from TMC, one from FFC, and one from ECMP employed males in this capacity.

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[29] The term social service provider will hereafter refer to the 43 persons responsible for the social service component regardless of job title.

Twenty-three social service providers (53.5 percent) were Mexican-American; 25.6 percent (11) were black; 9.3 percent (four) were white; 7.0 percent (three) were Puerto Rican; and 4.7 (two) were Cuban. Of the 23 Mexican-Americans, 20 were from TMC and one was from CUI. All 11 blacks were from FFC and ECMP. The social service providers at both SWGA centers were white. The Cuban and Puerto Rican social service providers worked at centers operated by FFC and ECMP.

While English was the primary language of 17 social service providers, Spanish was the native language of 25 home base social service providers. One respondent indicated that she was totally bilingual (English and Spanish) and therefore did not have a primary language. All of the social service providers who spoke Spanish as a first language also spoke English. By contrast, only two persons whose first language was English reported being able to speak Spanish as a second language.

Social service providers are a fairly well-educated group. Nineteen attained a high school degree and five more a General Education Degree (GED). Six social service providers matriculated to college. Two members of this group received two-year degrees; four possessed four-year degrees. Another 18.6 percent of these providers had not graduated from high school.

Social service providers on the average had remained at their current jobs for almost two years. A total of 14 social service providers (32.5 percent) had held their current positions for six months or less. Ten of these were from FFC; and the other four were from TMC. Another six persons had their current jobs from seven to 12 months. Sixteen social service providers had held their current positions for more than two years.

Social service providers said they had been employed at the center where they worked for an average of nearly three years. This indicates that this group had worked in other jobs for approximately one year before assuming their current responsibilities.

Eleven social service providers had worked at other MHS centers. All were from TMC programs. Five of these staff worked for more than five years at other programs.

When asked whether they had had experience in other preschool settings, 13 social service providers responded affirmatively. Eight social service providers from TMC had other preschool experience lasting more than 13 months. The MOP and CUI social service providers each had more than six months' experience of this kind. Two of the FFC and one of the ECMP social service providers had other preschool experience.

Sixteen social service providers throughout the 43 home base centers were taking courses related to their MHS responsibilities. Of those, eight were from TMC, four from FFC, two from ECMP, and one each from MOP and CUI.

Only nine social service respondents (20.9 percent) had received special credentials or certificates relating to their MHS work. Seven of the credentials were CDAs, five of which were held by center directors. Five of the CDAs were received by TMC and two by FFC staff.

Some social service providers stated that they were working toward a special credential or certificate. Four respondents, two from TMC, one from FFC, and one from CUI, were working on CDA credentials; another three, all from TMC, were working on bilingual/bicultural CDA certificates.

b. Training Provided to Staff Responsible for Delivery of Social Services

Many social services activities are covered in the training of Migrant Head Start staff. Elements of this component often overlap with those of other components, most notably parent involvement.

Only four social service providers from centers operated by FFC received preservice training specifically related to social services activities. One of these providers had received training in child abuse and another had training in parent involvement and child abuse. The other two received training in either social services or parent involvement activities. Approximately 36 hours of preservice training were provided by the FFC grantee to these social service providers.

Providers at the same four FFC centers received a total of 54 hours of inservice training, which was provided by grantee staff. Training focused on parent involvement and social service activities.

Four of the five ECMP social service providers received preservice training in the social services area. ECMP grantee staff provided a total of 104 hours of training to these staff members. The same providers received from the grantee staff 88 hours of inservice training related to social services.

One social service provider from SWGA received eight hours of preservice training, provided by the grantee, on child abuse and neglect. The other aide received no preservice training.

The social service specialist from the CUI center had no preservice or inservice training specifically related to her duties. However, the parent involvement specialist had 24 hours of preservice training in social services and parent involvement. The parent involvement specialist also had three hours of inservice training in these same areas. Preservice training was provided by Westinghouse Corporation; various social service agencies provided the inservice training.

Social service providers at TMC's 20 centers did not receive any pre- or inservice training relating to the social services component. Likewise, the MOP social service provider had no preservice or inservice training related to parent involvement or social services.

c. Service Delivery Activities

1) Recruitment

The recruitment of children for Migrant Head Start centers is included in the social services component, and theoretically the staff member responsible for social services is responsible for recruitment. In practice, other staff members, in addition to the social service provider, often share responsibilities in this area.

All of the MHS home base centers actively recruit children from migrant families. Nearly half of the parents with children enrolled were contacted at their homes by center staff. Considerably fewer children were recruited through other means. (See Table 47.)

TABLE 47

CHILDREN RECRUITED BY VARIOUS METHODS AT HOME BASE CENTERS *

Method	Number of Children	Percentage of All Children
Visits to parents' homes	612	23.6%
Radio, newspaper, or television messages	203	7.8%
Posters or billboards	152	5.8%
Community meetings	100	3.8%
Telephone or personal contact with community leaders	79	3.0%
Other	93	3.5%

*More than one method can be used to recruit children.

Telephone or personal contact with community leaders was used by only one grantee to any significant degree. SWGA made use of radio, newspaper, and television messages, and reported that 26.1 percent of their children were recruited through these public announcements.

Thirty-four home base centers enrolled all children meeting mimimum IMPD requirements on a first-come; first-served basis. The MOP and CUI programs as well as 85 percent of the TMC, 84 percent of the FFC, and 60 percent of the ECMP centers adhered to this policy.

Social service providers from the seven programs not following this policy specified three groups of children who were given preference. These were:

- Handicapped children,
- Children from families in need of assistance, and
- Children who were previously enrolled at the center.

Twenty-four centers took steps to identify and recruit children with previous Head Start experience. (See Table 48.)

TABLE 48

STEPS TAKEN AT HOME BASE CENTERS TO IDENTIFY AND RECRUIT CHILDREN WITH PREVIOUS HEAD START EXPERIENCE*

Steps	Number of Centers	Percentage of Total
Information from programs run by the same grantee is used	14	32.6%
Information from other programs is used	14	32.6%
Community contacts	11	25.6%
Radio, television, and/or newspaper messages	9	20.9%
Other	4	9.3%
No steps are taken	19	44.2%

*More than one step can be used to recruit children.

Information from other programs was used at one third of the centers. Other methods included posters, visiting the homes of previous enrollees, and contacting other social service agencies and schools. One center used the MSRTS to contact families who indicated that they were moving into the area.

Thirty-seven home base centers (86 percent) made special efforts to identify and recruit handicapped children. All of the SWGA, ECMP, MOP, and CUI sites followed these practices. Special efforts were also made by 90 percent of TMC and 71.4 percent of FFC centers.

2) Assessment of Family Needs

Because the social needs of migrant families fluctuate as weather and crop conditions change, it is necessary that regular contacts with families be made in order to identify their needs. This is one of the most important functions of the social service providers at MHS programs. The following table describes the frequency with which efforts are made to identify the social services needs of the families.

TABLE 49

FREQUENCY OF EFFORTS TO IDENTIFY THE SOCIAL SERVICE NEEDS OF MIGRANT FAMILIES

Frequency	Number of Centers	Percentage of Total
Always	17	39.5%
Usually	16	37.3
Sometimes	8	18.6
Seldom or never	1	2.3
Don't know	1	2.3
TOTAL	43	100.0%

As demonstrated in the table, more than 75 percent of the home base centers usually or always made contact with families to determine their social service needs. A social service provider from a TMC center reported that contacts were seldom made and the respondent at one FFC center did not know whether staff had attempted to assess the needs of families with children enrolled.

Individualized plans to help families meet their needs were usually developed at 18 MHS home base centers. Another 27.9 percent of the social service providers indicated that family plans were sometimes developed, while almost as many (20.9 percent) said the family plans were seldom or never developed. Four social service providers did not know if family plans of this type were developed at their centers.

The most common method used to determine a migrant family's social service needs was to visit parents' homes. This method was used at all but five centers. The table below shows the various methods used by the 43 home base centers to determine a migrant family's social needs. Centers often used more than one method.

TABLE 50

METHODS USED TO DETERMINE SOCIAL SERVICE NEEDS OF MIGRANT FAMILIES

Method	Number of Centers	Percentage of Total
Visits to parents' homes	38	88.4%
Interviews with parents at center	24	55.8%
Information on enrollment forms	19	44.2%
Questionnaires sent home	7	16.3%
Other methods	13	30.2%

3) Information on Social Services Given to Families

A list of available social services was always or usually provided to parents at 23 centers. Another 25.6 percent of the social service providers stated that a list was provided sometimes. Lists were seldom or never provided at 20.9 percent of the centers.

Literature given to parents of enrollees listing social service agencies were written either in English (18.6 percent), Spanish (seven percent), or both (62.8 percent). Bilingual lists were provided by 15 TMC and eight FFC programs.

4) Support Resources Available to and Used by the Centers

Social service providers were asked about the availability and use of 13 public and private community resources by their centers. As demonstrated in Table 51, if a community resource was available, a program would usually make use of it.

TABLE 51

AVAILABILITY AND USE OF COMMUNITY RESOURCES AT HOME BASE CENTERS (N=43)

	Public Health Clinic	Nutrition Services	Family Planning Services	Work Training Programs	Comprehensive Community Health Center	Migrant Health Center	Family Counseling Services	Mental Health Clinic	Medical Laboratory Services	Other Family & Child Services (Public & Private)	Psychological Services	Child Guidance Clinic	Armed Forces Medical Facilities
Available and Used	95.4%	76.7%	76.7%	79.1%	76.7%	62.8%	58.1%	53.5%	51.2%	51.2%	48.8%	27.9%	2.3%
Available but not Used	2.3%	4.7%	14.0%	9.3%	4.7%	-	23.3%	23.3%	16.3%	16.3%	18.6%	14.0%	9.3%
Not Available	2.3%	18.6%	9.3%	11.6%	18.6%	37.2%	18.6%	20.9%	32.6%	32.6%	27.9%	58.1%	88.4%

From the table above it can be seen that public health clinics were the most widely available and widely used community resource. The least used community resource, primarily because of its unavailability, was armed forces medical facilities.

Family counseling services and mental health clinics were available but not used at almost one quarter of the centers.

It is also interesting to note that migrant health clinics were the only community resource used whenever available.

5) Interaction and Collaborative Arrangements between the Centers and Other Support Agencies

Thirty-five MHS home base programs exchanged information with community services agencies, schools, and other organizations. These included all centers of all grantees except TMC and FFC. Table 52 shows the number of centers exchanging information with service organizations by type.

TABLE 52

CENTERS EXCHANGING INFORMATION WITH COMMUNITY SERVICE ORGANIZATIONS

Organization	Number of Centers	Percentage of Total
Medical facilities*	29	67.4%
Public welfare agencies	26	60.5%
Public health departments	12	27.9%
Educational institutions	10	23.3%
Manpower & work training programs	5	11.6%
Family health & rehabilitative services	4	9.3%
Legal aid	3	6.9%
Other**	14	32.5%

*Local medical facilities were clinics, hospitals, or the offices of private doctors.

**These are primarily church-affiliated charities, other Migrant Head Start centers, public utilities, or housing authorities.

Nearly two thirds of all centers exchanged information with local medical facilities and public welfare agencies. Approximately one out of four centers had information exchanges with health departments and educational institutions.

Periodic meetings were held with the staff of community service agencies, schools, and other organizations at 26 home base programs. All of the centers operated by three grantees (SWGA, MOP, and CUI) had followed this practice. Table 53 below shows the number of home base centers where staff met periodically with staff of other community organizations.

TABLE 53

HOME BASE PROGRAMS MEETING PERIODICALLY WITH COMMUNITY SERVICE ORGANIZATIONS

Organization	Number of Centers	Percentage of Total
Medical facilities	15	34.9%
Public welfare agencies	13	30.2%
Public health departments	9	20.9%
Educational institutions	4	9.3%
Manpower & work training programs	2	4.6%
Legal aid	2	4.6%
Family health & rehabilitative services	1	2.3%
Other	11	25.6%

Again, medical facilities and public welfare agencies were the community service organizations with which home base centers met most often.

Home base centers shared the responsibilities for providing families with needed services. Table 54 indicates the number of centers sharing responsibility for providing services with various other sources of assistance.

TABLE 54

PROGRAMS SHARING RESPONSIBILITIES FOR PROVIDING SERVICES TO MIGRANT FAMILIES

Organization	Number of Centers	Percentage of Total
Medical facilities	13	30.2%
Educational institutions	11	25.6%
Public welfare agencies	10	23.2%
Public health departments	6	13.9%
Manpower & work training programs	1	2.3%
Other	12	28.0%

Almost one third of all home base centers shared responsibilities for providing services to migrant families with local medical facilities. One fourth of MHS home base centers also often collaborated with educational institutions and welfare agencies.

Few social service providers indicated that letters of intent formalizing cooperative relationships with other agencies or organizations had been signed. Of the six centers pledging cooperation through letters of intent, four were from TMC, one was from ECMP, and one was from FFC.

A variety of agencies or organizations had given letters of intent to home base centers, including:

- Two public welfare agencies,
- A health and rehabilitative service center,
- A health clinic,
- An educational center,
- A fire department and a police department,
- A dairy council, and
- The United Migrant Association.

6) Agencies to Which Parents and Children were Referred

Social service providers referred 371 parents to community service organizations or agencies during the month preceding the survey.[30] Over half of the parents were directed to public welfare agencies or medical facilities. Table 55 shows the number of referrals to all types of community service agencies.

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[30] The CUI site did not make any parent referrals during this period.

TABLE 55

PARENT REFERRALS TO COMMUNITY SERVICE ORGANIZATIONS BY HOME BASE CENTERS

Organization	Number of Parents Referred	Percentage of Referrals
Public welfare agencies	116	31.2%
Medical facilities	95	25.7
Public health departments	30	8.2
Legal aid	21	5.6
Manpower & work training programs	17	4.6
Educational institutions	14	3.7
Family health & rehabilitative services	14	3.7
Housing authorities	14	3.7
Other	50	13.6
TOTAL	371	100.0%

An average of nine parent referrals was made to outside agencies by each center during the month preceding the survey.

Children in need of additional assistance were usually referred to local medical facilities. Fifty were referred to private doctors during the 30-day period preceding the survey. Other children were sent to public health and welfare agencies. (See Table 56.)

TABLE 56
CHILDREN REFERRED TO COMMUNITY SERVICE ORGANIZATIONS

Organization	Children Referred	Percentage of All Referrals
Medical facilities	283	71.7%
Public health departments	51	12.8
Public welfare agencies	22	5.6
Educational institutions	17	4.2
Other	22	5.6
TOTAL	395	100.0%

Four referrals from TMC were especially interesting in terms of where children were referred and the reasons for their referral. Two children were referred to the Easter Seal Society for physical therapy and health development problems. There were also two referrals made for eye problems -- one to the Lions Club and one to an optical company for eyeglasses.

Two thirds of the social service providers stated that they always followed up referrals to determine whether families received those services. Another 32.6 percent reported that center staff followed up referrals either usually or sometimes.

6. Parent Involvement

a. Profile of Parent Involvement Coordinators

Parent involvement is an integral part of the Migrant Head Start program. The parent involvement component of center delivery systems aims at increasing parents' awareness of, and influence on, their child's education. The duties associated with this program component are carried out by a variety of staff members, most notably program administrators and social service providers, at home base centers. (See Table 57.) This position was handled by persons who also had other responsibilities. Most of those individuals responsible for parent involvement also served as social service providers, center directors, or head teachers.

TABLE 57

POSITIONS HELD BY RESPONDENTS TO THE PARENT INVOLVEMENT MODULE

Positions	Number of Respondents	Percentage of Respondents
Social Service Provider	13	30.2%
Center Director	11	25.6%
Head Teacher	9	20.9%
Teacher	3	7.0%
Teacher's Aide	3	7.0%
Handicap Aide	2	4.7%
Parent Involvement Coordinator*	1	2.3%
Cook		2.3%

*The respondent held this position at the grantee level and, while responsible for nine home base centers, completed the module for only one.

Parent involvement coordinators[31] averaged 32 years of age. Fifty-five percent were under 30 years of age and only two were more than

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[31] The term parent involvement coordinator will hereafter refer to the 43 persons responsible for the parent involvement component regardless of job title.

50 years old. Parent involvement coordinators were predominantly women (81.4 percent). Two thirds (29) were Hispanics of whom 24 were Mexican-Americans. Eleven were black and three were white.

The primary language among parent involvement coordinators was Spanish. Seventy-five percent of Spanish-speaking coordinators were employed at TMC centers. All were bilingual. English was the primary language of the 19 remaining parent involvement coordinators. Only 26 percent of this group were fluent in Spanish.

Parent involvement coordinators had completed an average of slightly less than one year of education beyond high school. Twenty-six held high school diplomas or GED certificates as their highest degree. Three possessed two-year college degreees and six had four-year degrees. One person working in this capacity had received a Master's degree.

In general, parent involvement coordinators had held their current jobs for slightly less than two and one half years. Twenty-two of them, however, had less than two years' experience as coordinators at their centers.

Parent involvement coordinators are a moderately experienced group. Before assuming responsibilities as coordinators, these staff had worked for an average of nearly eight months in another capacity at their present centers. Eleven coordinators had accumulated an average of 4.5 years of experience at other Migrant Head Start centers. Notably, ten of these eleven were employed at TMC sites. In addition, 12 parent involvement coordinators had an average of 14 months' tenure at preschools other than Migrant Head Start. A majority of this group (eight) was again part of the TMC system.

To supplement their skills as parent involvement coordinators, 15 persons were enrolled in educational courses. Seven were from TMC, four from FFC, two from ECMP, and one each from the CUI and MOP sites.

One third of the parent involvement coordinators had received or were working toward a special credential or certificate relevant to their MHS work. The most frequently held certification was the CDA, which was held by seven persons, including two center directors and four head teachers. An equal number of people said they were working toward CDA certification, including two center directors, a head teacher, and a teacher. One TMC respondent received bilingual/bicultural CDA certification and two others were working toward certification in this area. One parent involvement coordinator at a TMC site had a Palatisha certificate.

Two parent involvement coordinators at FFC sites had received handicap training and another had completed parent involvement workshops. One coordinator was working on parent effectiveness training. Another coordinator, employed by the TMC, received creditation or certification in the areas of physical development, the use of learning materials, and communication with children. Still another person from a TMC center stated that she was being trained in social services work. The parent involvement coordinator at the MOP site had completed parent involvement workshops.

b. Staff Training in the Parent Involvement Area

To aid their staffs, 30 centers received training or technical assistance in how to get parents to participate in center functions. Parent involvement training was provided by grantee staff at ten of the 14 FFC centers. The ECMP grantee staff gave assistance to three of its centers and another received aid from a community college. Grantee specialists provided training at both SWGA sites. The TMC centers received training from grantee staff (five), from Southwest Educational Development Labs (six), or both (one). The MOP site was aided by IMPD. The parent involvement coordinator at the CUI center said that no assistance was received from any agencies.

c. Advisory Groups

One method of initiating greater parent participation in a center's activities is through advisory groups. These groups enhance the parents' awareness of their children's development and foster closer ties with the center. Advisory groups existed at 42 centers.[32] Two forums for parent involvement stand out--the Parent Advisory Committee and the Health Services Advisory Committee. Forty-one centers claimed to have the former while only 13 had the latter. The total known number of parents on other or advisory committees was 663.

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[32] No information was available concerning the 43rd, an FFC site, because the respondent did not know whether an advisory group existed.

TABLE 58

NUMBER OF PARENTS INVOLVED IN ADVISORY GROUPS BY GRANTEE

Grantee	Number on PACs*	Number on HSACs**	Other Parent Committees	Total	Average
FFC	191	6	31	228	16.3
ECMP	94	-	22	116	23.2
SWGA	7	3	-	10	5.0
TMC	243	25	29	297	14.9
MOP	4	-	-	4	4.0
CUI	5	3	-	8	8.0
TOTAL	544	37	82	663	15.4

*Parent Advisory Committees.

**Health Services Advisory Committees.

Ten of the 43 centers had additional parent groups whose combined membership was 82. Three of these committees--planning, policy, and governing--were of an administrative nature. The others--fund raising, screening, and parent representation--were more concerned with individual problems that might arise.

The largest grantees, TMC, FFC, and ECMP, also had the greatest parent participation in advisory groups. The ECMP, which is the smallest of the three, had the highest average number of persons on its parent and health services committees.

d. Parents Working at Centers

1) Paid Workers

Parent involvement coordinators at 16 sites said that their centers reserved funded staff positions for parents. A total of 29 parents worked at these centers. Parents worked at six additional centers which did not especially fund positions for them. Of the 22 centers which employed parents, half were operated by TMC. The others were five FFC and four ECMP sites, and one CUI site.

Nineteen of the parents were teacher's aides. (See Table 59.) Ten worked at TMC sites and nine at FFC sites. These parents constituted the largest group of paid parent staff members. Parent involvement coordinators at some sites knew that there were paid parents, but could not identify their positions.

TABLE 59

PARENTS AS PAID STAFF AT HOME BASE CENTERS

Position	Number of Parents
Teacher's Aide (TMC, FFC)	19
Center Director (TMC)	2
Head Teacher (ECMP)	1
Teacher (SWGA)	1
Handicap Aide (ECMP)	1
Health Aide (TMC)	2
Cook (TMC)	3
Bus Driver/Custodian (TMC)	1
Office Aide (FFC)	1
Not identified	14
TOTAL	45

While most parents were employed in positions which required limited, if any, formal experience and education, it is interesting to note that some parents held positions of responsibility, such as center director and head teacher. Qualified parents who serve in responsible positions can both be an example to other parents and facilitate center-parent communication, and may thus be a key to boosting parent involvement at MHS centers. The nature of the work performed by parents in positions of responsibility demonstrates to other parents their concern for the children's education. This, in turn, may allay some of the parents' fears and enable them to feel more comfortable in discussing their problems with staff members.

2) Volunteers

According to parent involvement coordinators, a total of 325 persons volunteered at home base centers. Of these, 72 percent were parents and 28 percent were not. (See Table 60.)

Parent volunteers are beneficial in two ways. Firstly, volunteers supply center staff with additional manpower. Secondly, volunteer positions allow parents to participate in center operations, giving them greater roles in their children's educational development.

TABLE 60

VOLUNTEERS AT HOME BASE CENTERS

Grantee	Parent Volunteers	Non-Parent Volunteers	Total Volunteers
FFC	18	13	31
ECMP	7	1	8
SWGA	13	3	16
TMC	136	73	209
MOP	23	-	23
CUI	37	1	38
TOTAL	234	91	325

Twenty MHS centers had volunteers on their staffs. They averaged 16.3 volunteers per center. Volunteers at 16 of these centers had children in the programs. Ten sites had volunteers who did not have children enrolled. Volunteers in the latter group were members of community organizations (five centers); high school students (three centers); and older siblings of children enrolled in the program (three centers).

The majority of the 234 parent volunteers were either teacher's aides (46.2 percent) or kitchen aides (23.6 percent). In addition, six parents at the MOP center were social services/parent involvement aides. Other volunteers helped with maintenance, special events, and fund raising.

Volunteers who were not parents included mostly persons paid from other sources, e.g., CETA and VISTA. Most of them acted as teacher's aides. Forty-eight of these 60 teacher's aides were at TMC sites. Social services/parent involvement, clerical, and health aides accounted for only 4.4 percent (four positions) of the non-parent volunteers. The services of the remaining 27 (29.7 percent) volunteers included maintenance, field trips, nutrition, and library reference.

e. Actions Taken to Involve Parents in Center Activities

1) Outreach Activities

To ensure that parents and children gain maximum benefit from their Head Start experiences, it is essential that the parents be kept abreast of center events. Migrant parents who work long hours have little time to participate in advisory groups, policy boards, and center events. Therefore, the centers make special efforts to reach parents and inform them of future activities. Information is transmitted in several ways including newsletters, home visits, meetings, and the media. Table 61 below illustrates the various methods used to inform parents of center programs.

TABLE 61

METHODS USED TO INFORM PARENTS ON CENTER PROGRAMS

Method	Number of Families	Families Reached
Note or letter sent with child	1191	55.3%
Home visits	983	45.7%
Newsletters	855	39.7%
Community meetings	485	22.5%
Media	251	11.7%
Other (telephone, posters, etc.)	337	15.7%

The method used most frequently to contact parents (except among FFC sites) was a note or letter sent home with the child. Home visits were used to reach 253 families at FFC sites as compared to 190 families reached by note or letter. Several centers reported using the telephone and parent meetings to transmit information.

2) Parent Training

Parent training focuses on teaching parents to assume a more active role in the growth and development of their children. This training usually consists of seminars, lectures, films, classes, and field trips.

During the one-month period preceding the survey, 262 parents at 21 centers received some type of training. Only the CUI center offered no training.[33] Health training, the training most frequently provided, was received by 75 of these parents. Almost one half of the 75 parents were instructed at FFC centers. The TMC sites provided the highest number of hours of health training per parent. Parents at those sites received 1.75 hours per person. The other grantees provided half an hour or less.

Fifty-four parents were provided child development education training for an average of slightly less than one and a half hours during the month. Seven parents at TMC centers (five at one site and two at another) received an average of 6.3 hours of training. Parents at the FFC sites received an almost equal amount. Parents at the ECMP sites, however, received considerably less instruction. The 44 parents at those sites were trained an average of 25 minutes per parent in child development/education.

Comparatively less attention was given to nutrition instruction over the same month. Only sites administered by the ECMP and TMC provided this training. Two TMC centers trained a combined total of 11 parents for an average of almost one hour and 15 minutes. The one ECMP center that held nutrition classes gave its 35 parents a total of two hours of instruction.

Eighty-seven parents received a total of 104 hours of other training over the span of the month. An average of 1.2 hours was spent instructing parents in the fields of:

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[33] The parent involvement coordinator at the MOP site did not know whether training was provided.

- High school equivalency (17);
- Child care during field trips (17),
- English (15),
- Parent involvement (11),
- Social services (11),
- Leadership (5), and
- First aid (2).

3) Social Gatherings

Activities such as social hours, picnics, and fiestas are effective tools in stimulating parent participation. They provide good opportunities for the parents to meet both the staff and other parents in a relaxed atmosphere. At these gatherings parents are ideally drawn into other activities designed to involve them in their child's growth.

Social gatherings were held at 33 centers during the current session. A mean of 29.8 parents attended these events. Other centers scheduled events to coincide with upcoming holidays.

Social gatherings were usually held once a month at 39.5 percent of all centers and less frequently at 30.2 percent. Three centers reported that they had them more frequently. Fifty percent more parents attended social gatherings than participated in advisory groups.

The biggest obstacle for parents wanting to attend gatherings and parent activities is time. The nature of migrant work often leaves many parents neither the time nor the energy to fully take part in their children's educational development. It is apparent, however, that in general parents do participate in activities when possible. From conversations with those parents who were interviewed, it is evident that they enjoy participating in this way.

E. PROBLEMS ENCOUNTERED BY HOME BASE PROGRAM STAFF

Center directors and staff directly responsible for each major service area at the 43 home base sites were asked to describe the most significant problems they face in their day-to-day work with migrant children and families. Their responses were recorded along with any recommendations made concerning how the problems that surfaced could be solved. These findings are presented in the following sections.

1. Problems Identified by Center Directors

All Migrant Head Start sites have a center director who coordinates between the grantee and the program staff. The center director looks to the grantee as the source of operating funds, administrative guidelines, program standards, and program support. At the same time, the center director is responsible for directing, organizing, and monitoring the activities of all staff working at the site level. The nature of the job puts the center director in a particularly good position to describe problems cutting across the diverse areas of program administration and service delivery.

The following table shows the problems most frequently mentioned by center directors.

TABLE 62
PROBLEMS IDENTIFIED BY CENTER DIRECTORS

Problems in Service Areas	Number of Centers	Percentage of All Centers
Delivering health services	15	34.9%
Involving parents in center activities	13	30.2%
Delivering social services	3	7.0%
Problems in Program Administration		
Funding and administrative difficulties	16	37.2%
Low wages of staff	14	32.5%
Insufficient facilities	9	20.9%
Transporting children and their families	6	13.9%

a. Problems in Specific Service Areas

The problem concerning service areas most frequently mentioned was providing adequate health services. The sources of the problem, according to center directors, are:

- Difficulties in locating and securing the services of qualified doctors, dentists, and other health care specialists;
- The high fees charged by health care professionals;
- The unavailability of funds required to pay for medical and dental screenings and treatment; and
- The need for better medical equipment and the lack of funds to purchase the required equipment.

The time required to secure the medical, dental, and developmental records of new enrollees, the incompleteness of many records which are transferred, and the number of times records are simply lost or otherwise unavailable were also cited as major impediments to health service delivery. On the other hand, many center directors felt that the transfer of health records was a problem of the past which has been largely resolved by the MSRTS and other techniques.

A few center directors stated that administrative problems at the grantee level complicated health service delivery problems. One respondent recommended a complete overhaul of the administrative procedures and practices at the grantee level.

Difficulties in getting parents actively involved in center activities -- as policy makers and as participants in learning activities -- was the problem area most frequently mentioned after health service delivery. More aggressive outreach efforts were commonly regarded as the best means of solving this problem. To most center directors speaking on this subject, outreach meant evening or weekend visits to the homes of parents by individual staff. In some cases, center directors pointed out that it was difficult to ask staff being paid little more than the minimum wage to contribute the added hours of overtime work required to significantly increase the frequency of home visits. One center director took the position that requiring some minimum level of participation on the part of parents would help. Another suggested that some system of rewards be established to attract parents to the centers.

Problems identified in the social service area were:

- The need for more frequent contacts between staff and parents -- primarily home visits -- to assess the social service needs of the entire family, to inform them of available services, and help them gain access to services meeting their needs;

- The need for more contact and coordination between Migrant Head Start staff and other service providers in the local communities; and
- The unavailability of services due to a variety of reasons including (1) difficulties in establishing the migrant family's qualifications, (2) shortages of resources and qualified service providers, and (3) high fees charged by the professionals who could help.

Here, as in the parent involvement area, the absence of staff with full-time responsibility for meeting performance standards in the social services area surfaces as a major source of problems. Any increases in current levels of outreach and social services-related activities would require staff with other major program responsibilities to work without pay in the evenings and on weekends.

b. Problems Relating to Program Administration

The major source of problems identified in this area by center directors was a shortage of funds. The major ramifications of the lack of sufficient funding cited by center directors are:

- Shortages of staff required to meet program objectives;
- Inability to enroll and serve migrant children and families in the locality who want to enter the program; and
- Low wage scales which put constraints on the quality of staff willing to work at Migrant Head Start centers and contribute to high staff turnover rates as able staff move on to better paying jobs.

Recommendations offered here were establishing a higher wage scale for existing positions, and increasing the number of staff at a site. This, of course, relates back to the core need for more program funds.

Another facet of the funding problem was the need to upgrade and/or expand existing facilities cited by nine center directors. Some respondents stated that if funds were available, they would move to a new location. Center directors who expressed these needs generally stated that they wanted facilities which would accommodate more children.

Some center directors mentioned a desire to have more influence on grantee-level allocations of funds to the individual sites. They did not question the central locus of decisionmaking on budgets at the grantee level. But they wanted more input and felt their insights and suggestions could be used to good effect.

A limited number of center directors complained that the record-keeping and reporting requirements imposed by grantees resulted in an inordinate amount of their time, and the time of their staff, being consumed in paper work.

These individuals recommended streamlining record-keeping and reporting formats. Two center directors added that the grantee administrative structure should be evaluated and reformed.

c. Other Problems Cited

Other problems cited by center directors were:

- Costs of providing transportation for children and families;
- High rates of absenteeism and high turnover rates for enrollees;
- The need to open home base programs earlier in the fall;
- The poor housing and living environment of children and families served by Migrant Head Start programs.

It is worth noting here that problems cited are concentrated in the health, parent involvement, and social services areas. While funding and staffing problems affect the education and nutrition areas, no problems specific to these components were mentioned by center directors.

2. Problems Cited by Head Teachers

Lack of parent interest in program activities and inadequate funding were the problems most frequently mentioned by head teachers. Responses of this group concerning problems encountered in service delivery are shown, in ranked order, in the following table.

TABLE 63

PROBLEMS ENCOUNTERED BY HEAD TEACHERS AT MHS HOME BASE CENTERS

Problem	Number of Centers	Percentage All Centers
Lack of parent interest	16	37.2%
Budget too low	16	37.2%
° Insufficient equipment	15	34.9%
° Need for more staff	10	23.2%
° Lack of qualified staff	8	18.6%
° Lack of facilities	8	18.6%
° Lack of sufficient space	7	16.3%
Language barrier	5	11.6%
Health of children	3	7.0%

Respondents cited various causes for the lack of parent interest: the working hours and low educational level of parents; their distrust of institutions; the inability of center staff to understand them; and a lack of staff to do required outreach work. The lack of parent interest so prominent here is intimately related to the more general problem of involving parents in program activities cited by almost one third of center directors interviewed. The language barrier problem cited by five head teachers exists in the classroom context but goes beyond it, contributing to difficulties in involving parents in programs.

As discussed in the section on problems cited by center directors, inadequate funding is also a problem with many ramifications. The problems of insufficient equipment, need for more staff, lack of qualified staff, lack of facilities, and lack of sufficient space all relate to the funding issue.

3. Problems Encountered in Health Services Delivery

One of the duties of Migrant Head Start health administrators is to identify the health problems of both children and their families. Below is a table of the problems cited by the individuals responsible for health services at Migrant Head Start home base centers.

TABLE 64

PROBLEMS IDENTIFIED BY HEALTH ADMINISTRATORS AT MHS HOME BASE PROGRAMS

Problem	Number of Centers	Percentage of All Centers
Problems specific to children	15	34.9%
Insufficient health education for parents	9	20.9%
Inadequate resources for providing screenings	8	18.6%
Too little money budgeted for health services	8	18.6%
Insufficient referral for treatment and follow-up	6	13.9%
Need for more qualified health personnel at program site	6	13.9%
Problems specific to families	6	13.9%
Need for more cooperation between Head Start and health professionals and organizations in community	4	9.3%

Many specific health problems cited by respondents were attributed to poor hygiene. Health administrators at four sites said that impetigo was a widespread, recurring problem. The proposed short-term solution was to bathe the children. But in the long run health specialists said that the parents must practice better hygiene. Colds, lice, deficient diets, and dental problems were also cited as problems which could be prevented through health education to parents supported by available medical facilities.

The families of children in Migrant Head Start programs suffered from many of the same afflictions as the children. The remedies, according to the health administrators interviewed, were, again, parent education and improved health services.

Eight centers reported insufficient screening for medical, dental, and developmental problems. Limited staff and shortage of funds were cited as impediments to faster and more efficient screening. One FFC respondent said transportation to the locations where screenings were performed was a problem. A TMC respondent said that parents often do not approve of screening for their children and that educational sessions were required to stress the importance of this screening to them. Six centers had difficulties in providing proper follow-up and referrals for treatment of problems diagnosed by screenings.

To reach parents, nine health administrators proposed that improved health education programs be implemented. Five thought training should be done through workshops. Two others felt that the dissemination of printed literature would serve this purpose.

Respondents who said that their centers needed more qualified health personnel and/or funds could offer no solutions except to ask for the additional staff and money.

Additional health-related problems fall primarily in the administrative area. Three health administrators complained of problems with immunization records. Another administrator complained that it took an hour to complete the paper work related to each child's dental visits. The proposed solution was that more staff could be hired to help with the administrative details.

Contagious diseases were reported at two sites. The health administrator at one FFC site said hepatitis, which was a county-wide problem, affected the migrant children and their families. A TMC center reported high instances of rubella.

4. Problems Encountered in Nutrition Services Delivery

As already noted, nutrition service delivery was not a major problem area according to center staffs. Individuals responsible for nutrition services raised specific problems in this area at only 30 percent of the centers visited. These included nine TMC centers and four centers operated by FFC.

The nine respondents cited insufficient knowledge concerning the nutritional value of foods as a major problem MHS parents shared with many other members of the community. (See Table 65.) Eight stated that more nutrition education was required to solve this problem. One specified the need for the dissemination of information about the food value of vegetables. In addition, one TMC food manager added that parents needed more money for the purchase of food. Another TMC respondent recommended educational training in the nutritional area for the center staff who could in turn assist migrant families in the surrounding community.

TABLE 65

PROBLEMS IDENTIFIED BY FOOD MANAGERS AT MHS HOME BASE PROGRAMS

Problem	Number of Centers	Percentage of All Centers
Insufficient knowledge concerning nutritional value of foods	9	20.9%
Inaccessability of food markets	3	7.0%
Other problems	5	11.6%

The problem of inaccessibility of food markets, cited by three food managers, stemmed from the remote locations of the centers. They stated that low incomes prevented many families from buying certain foods. One TMC respondent thought that a nutrition education program might help alleviate the problem. That is, parents could learn to substitute certain foods for those they could not afford to buy and still have balanced meals.

Only one respondent stated that the inaccessibility of public assistance (food stamps, AFDC, WIC) was a problem. Another said that more parents should be encouraged to participate in meals at the center to stimulate interest in their child's diet. Impotable tap water in a kitchen at an FFC site was the cause of some inconvenience.

Most of the nutrition problems were traced to insufficient knowledge on the part of parents and their inability to pay for more nutritious foods. Increased efforts to provide more parents with information and training was the most commonly recommended solution to this problem.

5. Problems Encountered in Providing Social Services for Children and Families

Problems in dealing with other social service agencies were the primary concern of MHS staff responsible for program performance in the social services area. The frequency with which these and other problems occurred is shown in Table 66 below.

TABLE 66

PROBLEMS IDENTIFIED BY SOCIAL SERVICE PROVIDERS

Problem	Number of Centers	Percentage of All Centers
Problems with social service agencies	15	30.2%
Lack of parent involvement	9	20.9%
Center personnel problems	5	11.6%
Transportation for children and families	5	11.6%
Other problems	8	18.6%

Problems encountered in dealing with local social service agencies include:

- Interpretations of eligibility requirements on the part of local social service agencies which, in the opinion of respondents, improperly denied migrant workers access to needed services;
- Limited hours in which services are available at local agencies which often made it difficult for parents to keep appointments and use available services; and
- The absence of Spanish-speaking staff at local social service agencies which made communication between these agencies and the Hispanic community difficult.

Transportation was also cited as an obstacle to family use of services in five cases.

A number of recommendations were offered to resolve eligibility problems. The CUI respondent said that if the income requirements were

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lowered, more parents would be eligible for medical cards through the State Department of Human Resources. Social service providers at TMC and SWGA sites stated that a single set of guidelines should be drafted standardizing the definition of migrant workers since definitional disparities between various agencies were the major source of eligibility problems. An FFC respondent recommended broadening the definition to include seasonal farmworkers so they would become eligible for additional services.

Respondents who regarded the limited hours that social service agencies offer their services as a major problem suggested that these hours be extended into the evening, allowing parents to seek out these services after they come home from work. One recommended that parents be granted a paid day off from work occasionally so that they could take advantage of services.

Parent involvement problems in this MHS service component were generally linked to the need for more social service specialists at the centers. The consequences of this shortage of trained staff were said to be:

- Inadequate needs assessment, follow-up, and support activities designed to inform parents of available resources and actively assist them in accessing these resources, and
- Confusion on the part of parents concerning what services were available and which they were eligible for.

Other dimensions of parent involvement were reluctance on the part of parents to discuss their needs with center staff and the unwillingness of a few parents to take their children to the doctor for medical treatment.

Transportation problems contributed to difficulties in involving parents in social services delivery activities according to four respondents.

As in the health and nutrition areas, parent education efforts were often recommended by staff who identified lack of parent involvement and interest as major obstacles to service delivery.

6. Problems Associated with Involving Parents in Center Activities

Problems in meeting parent involvement objectives were cited by 38 of the 43 staff responsible for service delivery in this area. Eighty-nine percent of the respondents at these 38 centers mentioned more than one problem.

TABLE 67

PARENT INVOLVEMENT PROBLEMS CITED BY STAFF AT MHS HOME BASE PROGRAMS

Problem	Number of Centers	Percentage of All Centers
Work hours of parents (too tired)	22	51.2%
Insufficient interest	10	23.2%
Unavailability of baby-sitters	6	13.9%
Transportation for families to center events	4	9.3%
Other problems	19	44.2%

Long working hours was the problem most frequently cited as an obstacle to parent participation in center activities. Half of the centers reported that these hours often leave parents too tired to become actively involved. This problem cuts across programs operated by all grantees. Parent involvement coordinators offered a variety of solutions to this problem. They include:

- More home visitations by center staff,
- Take-home activities for parents and children,
- Night workshops and meetings,
- Convenient times for meetings (i.e., weekends),
- Provision of transportation by centers, and
- More effective use of printed materials to stimulate parent interest in center activities.

Parents of Head Start enrollees have one or more young children to care for. Therefore, it is necessary that arrangements be made for someone to watch the children if the parents are to participate in many of the center activities. This care could be provided either in the family's home or at the center. Six parent involvement coordinators said that there were no adequate babysitting services available at their centers. All of them said that sitters were needed at parent meetings.

Transportation was also a problem for some parents. At sites where this problem surfaced, staff felt the center should be providing transportation for parents who required it in order to participate in center activities.

Other problems associated with increasing parent involvement were: (1) staff participation, (2) unfamiliarity of parents with the program, and (3) language barriers. The recommended solutions to these problems were rather straightforward. Center staff, through visits, the media, letters, etc., must reach parents with explanations of the

Migrant Head Start program. In addition to understanding what the centers are doing for their children, parents must be told what is expected of them. As for the language problem, more Spanish-speaking staff were recommended as the solution.

The problem of staff participation has several dimensions. A regional level parent involvement coordinator responsible for nine TMC centers provided the following insights into problems in organizing the parents into effective advisory groups.

First, she said that her workload was too heavy for one person. Since Parent Advisory Committee (PAC) meetings are the primary places of parent interaction with staff, she suggested that two parent involvement specialists assist the center parent involvement coordinators in organizing and conducting the PAC meetings. More meetings would allow for more personal contact between staff and parents.

Second, she said that teachers and teacher's aides often do not participate in PAC meetings. In addition to making home visits, she would like to see half the teachers and teacher's aides attend the PAC meetings on a rotating basis. The presence of these people might also alleviate some of the confusion which she said reigns at many of the meetings.

Finally, she said that more activities should be held which would demonstrate the centers' appreciation for the help given by the parents. These events might be fiestas, parties, or award ceremonies at the end of the school year.

V. FINDINGS: MIGRANT FAMILIES AND CHILDREN USING HOME BASE PROGRAMS

The profiles of the migrant families and children and their relationships with the Migrant Head Start delivery system through home base centers are presented in this section. Interviews with randomly selected samples of families and children (see Section III, Methodology) and the records of the children selected are the primary sources of data for these profiles.

A. PROFILE OF MIGRANT FAMILIES

1. Respondents

Interviews were conducted with 360 parents (or guardians) of children enrolled in home base programs. Three hundred and eleven respondents were mothers of migrant children and 34 were fathers. In 15 cases, someone other than a parent, usually a close relative, responded to questions. Among the persons interviewed, there were 224 Hispanics, 109 blacks, and 27 whites. Hispanic families were predominantly at sites in the Southwest and were also found in significant numbers in Florida. Black and white families interviewed were found almost exclusively in the Southeast.

2. Demographic Data

The typical migrant family with a child enrolled in a home base program consisted of six people. Seventy percent were nuclear families, usually consisting of a father, a mother, and three to four children. Thirty percent were extended families that included grandparents, aunts, and uncles.

Mexican-Americans constituted 96 percent of the Hispanic families interviewed. The remainder were Puerto Rican, Cuban, or Latin American.

On the average, fathers of MHS enrollees were 33 years old. Mothers were three years younger.[34] The mean age of children from these families who were enrolled in MHS programs was four years and nine months.

The typical mother interviewed had completed the eighth grade. Fathers of MHS children averaged seven years of formal education. Twenty-one percent of the parents finished high school and 2.3 percent had attended college.

3. Housing

Seventy percent of the families lived in towns with populations ranging from 2,500 to 25,000. The remainder lived either in rural areas (14.2 percent) or larger towns and cities (4.2 percent). Whereas most of the families resided in small towns, 60 percent of those at SWGA sites lived in the country.

Of the 158 families for which observations were made, 101 (64 percent) lived in detached single-family units.[35] Nearly one half (47.5 percent) of these families owned their homes. Fourteen percent of the families interviewed at home were living in mobile homes, while 6 percent lived in apartments, another 6 percent lived in migrant camps, and 3 percent lived in multiunit houses.

Thirty-eight percent of the families lived in housing that was in good condition. These homes were clean, well kept, and structurally sound. Another 39 percent lived in homes that had not been as well maintained but where most of the facilities (e.g., plumbing and electrical systems) were in working order. The remaining families (23 percent) resided in substandard housing. Faulty sewage systems and deteriorating structures were the most common problems observed in these homes.

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[34] Information was not available for 53 fathers and eight mothers.

[35] The majority of the respondents (55 percent) were interviewed at the MHS center, making observations of their housing impossible. Of these 199 respondents, 71 reported that they own their place of residence.

4. Employment and Income

At least 83 percent of the fathers of families interviewed were employed. Fifty-nine percent of the fathers of the MHS enrollees were primarily engaged in agricultural work, while 22 percent had non-agricultural jobs and two percent did both. One father was unemployed, and 16 percent were not with the family.

More than half of the fathers who were engaged in agricultural employment did general field work such as picking and hoeing. Others operated farm equipment or supervised farm crews. Many of the fathers were employed in food processing plants and packing houses.

Among the fathers holding non-agricultural jobs, one fourth worked in factories. Others were employed as construction workers, mechanics, and carpenters.

Nearly one third of the fathers worked a 40-hour week. Twenty-six percent worked more than 40 hours a week while another 9.4 percent worked less than 30 hours a week.

Fifty-six percent of the mothers worked. Thirty-seven percent of the mothers said they did agricultural work. Like their spouses, approximately one third of the mothers usually spent 40 hours a week at their jobs. Another 16 percent worked less than 30 hours and 6 percent worked more than 40 hours a week.

Table 68 shows the incomes of families with children enrolled in home base programs. Forty-four percent of the families sampled reported earnings of less than $6,000 in 1978.[36]

TABLE 68

INCOMES OF FAMILIES WITH CHILDREN ENROLLED IN HOME BASE PROGRAMS (1978)

Dollars Per Year	Percentage of Families Sampled
0 - 1,999	7.8%
2,000 - 3,999	19.7
4,000 - 5,999	16.9
6,000 - 7,999	14.7
8,000 - 9,999	10.0
Over 10,000	6.4
Don't know	23.6
No answer	0.9
TOTAL	100.0%

Field work or work associated with agriculture was the major source of income for most families. This was the sole source of income for 51 percent of the families. An additional 9.4 percent made more than half of their yearly incomes as farm laborers.

Over three fourths of the families from MOP, CUI, and ECMP grantees depended on agriculture for most of their income. The families from other grantees, however, relied more heavily on non-agricultural sources for their incomes. Seventeen percent of the families received no money through agricultural work. Most of these families were found in the FFC and SWGA programs where an average of 30 percent were employed in non-agricultural work.

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[36] Eighty-eight respondents did not supply income data.

5. Use of Community Social Services

Half of the migrant families relied on one or more social service agencies for assistance. Slightly less than 40 percent of them received food stamps to supplement their incomes. Women, Infants and Children (WIC) benefits were used by ten percent of the families. Table 69 illustrates that other services were used substantially less often.

TABLE 69
TYPES OF SOCIAL SERVICES RECEIVED BY FAMILIES

Service	Percentage of Families
Food Stamps	39.7%
WIC (Women, Infants, and Children)	10.8%
MEDICAID	7.2%
Aid to Families with Dependent Children	6.4%
Family planning	5.8%
MEDICARE	4.4%
Supplemental Security Income	2.2%
General assistance	1.9%
Legal assistance	0.3%

Six percent of the families reported having problems using these services. The majority of these problems stemmed from the inability of the migrant families to meet inflexible residency and income requirements. Approximately one out of four parents with complaints cited the staffs at the agencies as an obstacle and under one percent had difficulties getting the services.

Supplemental education and training programs were being attended by parents in 8 percent of the families. Eighty percent of those enrolled were mothers and 20 percent were fathers. They usually took basic education or vocational training courses. Some were enrolled in CETA and manpower training programs to learn professional skills.

6. Cultural Circumstances in the Home

Two out of three migrant homes had a minimum of four books that could be read to the children. Twenty-eight percent reported having 15 or more books, while only one third of the families possessed fewer than four children's books.

The number of books in a home did not necessarily correlate with how often someone read to the children. While 66 percent of the families had four or more children's books, almost half of the migrant families did not read to their children on a regular basis. Thirty-three percent of the parents read to their children several times a week and 20.3 percent stated that they usually did so on a daily basis.

Two primary languages, Spanish and English, were spoken in the migrants' homes. Spanish was the dominant language for 53.6 percent of the families, while English was spoken most frequently by 44.7 percent of the households. Among the Spanish-speaking families, 33.9 percent also used some English. In homes where English was usually spoken, Spanish was hardly ever used. Ninety percent of the families at the southwestern locations (CUI, MOP, and TMC) converse in Spanish, while a majority of the families at the southeastern sites speak English.

B. PROFILE OF CHILDREN AT HOME BASE CENTERS

The ages of the children enrolled in home base programs ranged from under one year to seven years old. The largest portion (69.4 percent) was between four and six years old. Slightly more than half of the children (52.2 percent) were males.

TABLE 70

AGES OF CHILDREN IN HOME BASE PROGRAMS

Age	Percentage of Children
Less than 1 year	0.8%
Between 1 - 2 years	1.9%
Between 2 - 3 years	3.3%
Between 3 - 4 years	11.9%
Between 4 - 5 years	34.7%
Between 5 - 6 years	34.7%
Between 6 - 7 years	8.9%
More than 7 years	1.9%

Ninety-nine percent of the children who were under three years old were enrolled at ECMP sites. This is explained by the fact that ECMP enrolled 83 children at two child care centers for children under three. These children accounted for one third of the total ECMP enrollment. The remaining centers usually served preschool-aged children.

Sixty-two percent of the children sampled were Hispanics, 96 percent of whom were Mexican-Americans. All of the children sampled at the MOP center and nearly all those at CUI and TMC programs were Hispanics. Hispanics comprised 44.8 percent and 30.9 percent of the ECMP and FFC enrollments, respectively. Four percent of the SWGA children were Hispanics.

The SWGA sites were primarily composed of blacks (62 percent) who made up 31 percent of the overall MHS enrollment. Aside from the SWGA sites, large black populations were found at the FFC and ECMP centers. Fifty-nine percent of the FFC children and 45 percent of those at ECMP sites were black. Children from white families comprised 7.2 percent of the sample. Sixty-nine percent of these were enrolled at SWGA sites.

The language proficiency of the children sampled was tested through the use of the Bilingual Syntax Measure. Both English and Spanish versions of the BSM were administered to all children except:

- Those who were too young to be tested by the BSM, which is designed for four- to nine-year-olds;
- Those who were sick or absent for other reasons during the study period; and
- Children whose shyness made it impossible to get a valid reading.

Both the English and Spanish versions of the BSM measure proficiency on a scale of one to five. The meaning of the proficiency levels assigned to children on the basis of responses to questions on the BSM test is described below:

Level 1: No English or Spanish

Child understands little or nothing of the language and is not able to speak it.

Level 2: Receptive English or Spanish

Child understands varying amounts of the language and produces some verbal routines, but cannot use the language to communicate thoughts and opinions.

Level 3: Survival English or Spanish

Child can communicate, with difficulty, using a combination of simple speech, gestures and an occasional word from their primary language. Short grammatical words (the, a, is), verb and noun endings, and pronouns (he, she, it, them) are often misformed or omitted.

Level 4: Intermediate English or Spanish

Child has little difficulty communicating ideas in the language; controls basic grammatical structures, e.g., plural forms, verb endings, articles, and pronoun forms. However, child does not fully control more difficult structures such as regular and irregular past forms, past participles, and the conditional form (would).

Level 5: Proficient English or Spanish

Native or near native proficiency, comparable to native speakers their own age.

Among children sampled, 21 percent were too young to test, 8.6 percent could not be tested due to shyness, and another 5.3 percent were either sick, otherwise absent, or handicapped. The following table illustrates BSM-English proficiency levels by age for the 65 percent of the sample from whom results were obtained. Included, as will be shown in later tables, are native speakers of both Spanish and English.

TABLE 71

BSM-E PROFICIENCY LEVELS BY AGE

Age in Months	1 No English	2 Receptive English	3 Survival English	4 Intermediate English	5 Proficient English	Total
42 - 47	0	0	1	1	0	2
48 - 53	19	6	6	2	0	33
54 - 59	29	10	13	4	2	58
60 - 65	19	11	22	6	1	59
66 - 71	20	7	10	4	2	43
72 - 77	5	5	5	3	1	19
Over 78	4	2	8	3	1	18
TOTAL	96	41	65	23	7	232

Twenty-eight percent of the children tested had "survival English" (Level 3) proficiency scores and 18 percent had "receptive English" (Level 2) scores. Forty-one percent spoke no English.

The following table shows a breakdown of the BSM-E test results by the ethnicity of children tested.

TABLE 72

BSM-E PROFICIENCY LEVELS BY ETHNICITY OF RESPONDENTS

Ethnicity	1 No English	2 Receptive English	3 Survival English	4 Intermediate English	5 Proficient English	Total
Hispanic	81	39	12	9	1	142
Black (not of Hispanic origin)	10	2	49	7	1	69
White (not of Hispanic origin)	4	-	4	7	5	20
American Indian/ Native American	1	-	-	-	-	1
TOTAL	96	41	65	23	7	232

While the fact that 84 percent of the children tested were under six years old tends to explain the comparatively low BSM-E scores, Table 72 provides a second explanation: 61 percent of the children tested were Hispanics, nearly all of whom spoke English as a second language. Among Hispanic children, 57 percent spoke no English and 91 percent scored at Level 3 or below. In contrast, 82 percent of the black and white children attained or exceeded Level 3, while 2 percent scored at Level 2. Sixteen percent spoke no English.

The following table illustrates the BSM-Spanish test results by age for the same group of children. Spanish proficiency scores were obtained for 74 percent of the children sampled.

TABLE 73

BSM-S PROFICIENCY LEVELS BY AGE

Age in Months	1 No Spanish	2 Receptive Spanish	3 Survival Spanish	4 Intermediate Spanish	5 Proficient Spanish	Total
42 - 47	2	0	0	0	0	2
48 - 53	23	4	5	4	4	40
54 - 59	36	5	5	2	19	67
60 - 65	29	3	1	6	31	70
66 - 71	15	1	2	5	23	46
72 - 77	7	1	1	1	12	22
Over 78	11	-	-	-	8	19
TOTAL	123	14	14	18	97	266

While the frequency of Level 1 scores is still relatively high (46 percent), the BSM-S results, in contrast to the BSM-E outcomes, show a substantial number of children (36 percent) at Level 5. This increase in proficiency scores can be attributed to the fact that Spanish was the first language of 61 percent of children tested using the BSM-S while English was the first language of only 38 percent of children responding to the BSM-E. The following table provides a breakdown of the proficiency levels of children taking the Spanish version of the test by ethnic group.

TABLE 74

BSM-S PROFICIENCY LEVELS BY ETHNICITY OF RESPONDENTS

Ethnicity	1 No Spanish	2 Receptive Spanish	3 Survival Spanish	4 Intermediate Spanish	5 Proficient Spanish	Total
Hispanic	24	13	14	18	97	166
Black (not of Hispanic origin)	79	-	-	-	-	79
White (not of Hispanic origin)	19	1	-	-	-	20
American Indian/ Native American	1	-	-	-	-	1
TOTAL	123	14	14	18	97	266

Among Hispanic children tested, 58 percent scored at Level 5, while 78 percent ranked at Level 3 or above. With one exception, black and white children in the sample had Level 1 Spanish proficiency scores.

BSM-E and BSM-S proficiency scores can be combined to provide a measure of language dominance. Language dominance is measured on the following scale:

(1) bilingual

(2) Spanish dominant

(3) English dominant

(4) Spanish monolingual

(5) English monolingual

Dominance scores can be arrived at only when children are tested in both languages and score above Level 3 (survival English/Spanish) in one of the two. Only 38 percent of the 360 children sampled met these criteria. The following table shows the language dominance of these children.

TABLE 75
LANGUAGE DOMINANCE BY AGE

Age in Months	1 Bilingual	2 Spanish Dominant	3 English Dominant	4 Spanish Monolingual	5 English Monolingual	Total
42 - 47	-	-	-	-	-	1
48 - 53	-	3	-	5	-	8
54 - 59	-	1	-	20	5	26
60 - 65	-	3	-	32	7	42
66 - 71	-	5	1	23	5	34
72 - 77	-	1	1	10	2	14
Over 78	-	2	-	6	3	11
TOTAL	0	15	2	96	23	136

There were no fully bilingual children. Eighty-eight percent of the children who registered dominance scores were monolingual. In this group, all 96 of the Spanish speakers were Hispanic children. Among the 23 monolingual English speakers, 12 were white, eight were black, and three were Chicanos.

Thirteen percent of the children had some ability to use both English and Spanish. Nearly all were Hispanic children with Spanish dominant scores.

1. The Developmental History of the Children

At the time a child is enrolled in a program, centers record parental assessments of the child's developmental progress. Parents are asked to describe their child's development in a series of general areas as "fast," "average," or "slow." The following table shows the distribution of their responses.

TABLE 76

PARENTS' ASSESSMENT OF DEVELOPMENTAL PROGRESS OF CHILDREN AT HOME BASE CENTERS

Area	Fast	Average	Slow	Not in Records	Not Applicable
Walking, climbing, running	17.5%	56.4%	3.1%	18.6%	4.4%
Talking	11.1%	58.6%	6.9%	18.6%	4.7%
Playing with toys, coloring, drawing	9.7%	65.3%	1.9%	18.6%	4.4%
Understanding what is said to him/her	9.4%	65.3%	1.1%	19.7%	4.4%
Getting along with children his/her age	10.0%	65.3%	1.1%	18.1%	4.4%

Most children were seen as average in their development.

2. History of Illnesses of Children

Each Head Start center is to maintain a record of their enrollees' medical histories. This includes a record of the illnesses which the children have contracted. The following chart illustrates histories of illnesses of the children sampled. Information from parents and from center health specialists is combined to complete this record.

TABLE 77

HISTORY OF ILLNESSES OF THE CHILDREN
AT HOME BASE CENTERS

	Percentage of Children		
Illness	Yes	No	Not in Records
Measles (Rubeola)	13.1%	82.2%	4.5%
Mumps	6.1%	88.1%	5.3%
Chicken pox	17.2%	76.9%	5.6%
Rubella (3-day or German measles)	7.5%	85.8%	6.7%
Whooping cough	2.5%	91.1%	6.3%
Seizures, fits, or spells	2.5%	91.1%	6.3%
Tonsillectomy	2.8%	88.9%	8.3%
Exposure to tuberculosis or to a person with chronic cough	2.8%	88.1%	9.2%
Frequent bedwetting (now)	13.3%	80.3%	6.4%
Other serious diseases	8.9%	84.2%	6.9%

The illnesses most frequently contracted were rubella, chicken pox, and measles. Pneumonia, bronchitis, and asthma were also cited, but occurred less frequently.

Slightly less than 20 percent of the children had been hospitalized in the past.[37] Children were hospitalized for two main reasons. The first was for an illness such as pneumonia or tonsillitis. The second involved emergencies like broken bones, accidental poisoning, and high fevers. A few children had undergone surgery to correct problems such as cleft lips and hernias.

C. MOVEMENT OF CHILD AND FAMILY

1. Relocations Over Past Year

More than two fifths of the families (154) reported that they had relocated at least once in the past year. The percentage of families who relocated differed greatly among the six grantees. The highest percentage of migrating families had children enrolled at ECMP (85 percent) and TMC (60 percent) sites. Thirty-two percent of the FFC families, 20 percent of those at CUI, and 17.8 percent of the MOP families had relocated. Only 7.7 percent of the SWGA families had moved from their current locations during the previous 12 months.

Families who did relocate moved an average of twice. Seventy-five percent of the families who migrated moved from State to State to find work; 25 percent were intrastate migrants. Only 4 percent of the families who had relocated had worked in more than one of the three major migrant streams.

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[37] Information for 18.4 percent of the enrollees was not available from center records.

Families from FFC and ECMP home base sites had moved both northward along the East Coast and westward to States such as North and South Carolina, New York, Ohio, Illinois, Texas, and Colorado. Parents from SWGA, the third southeastern grantee, went only to Kentucky during the past 12 months.

Families leaving TMC sites traveled to western and midwestern States, including California, Wyoming, North Dakota, Wisconsin, Illinois, and Ohio.

CUI families reported migrating intrastate as well as to Arizona and Washington, and MOP families who left Arizona traveled to California.

Nearly half of the migrant families (52.5 percent) stay at the same location each winter. Almost two out of three families rented their homes at these sites while 36 percent owned them.

According to center records, over the past year 49 percent of the children have relocated with the family when their parents moved to find agriculturally related work.[38] Ninety-one percent of ECMP and 74 percent of TMC children underwent this process, compared to only 12 percent of the FFC and 1.9 percent of the SWGA enrollees.

2. Expected Relocations During 1979

Forty-three percent of the families reported that they planned to move between the time of the interview[39] and October 1979. In addition, 11 percent did not know whether they would be moving and 1 percent did not answer the question.[40] Most of the families who planned to move were from TMC and ECMP sites, which had the highest percentage of families that migrated in the past year. Ninety percent of all families migrating said they would move in search of agriculture-related work. The remaining ten percent said they would move to find nonagricultural work, to allow their children to continue their education, or to return to a home base area.

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[38] Records were not available for 34.4 percent of the children sampled.

[39] Interviews were conducted in March, April, and May 1979.

The average family that said it would move consisted of five people. In 87 percent of the cases, the child would remain with the family. Ten percent of the parents who planned to relocate did not plan to take their children with them. The remainder were undecided as to whether to take them when they moved.

Nineteen percent of all families sampled planned to remain in their home base areas but said that someone from the family would move to find work. At least one member from three fifths of the families sampled planned to move.

The majority (88.2 percent) of families migrating planned to move to a specific destination area. Over one third of the parents already had contracted work with their employer in the area to which they would move. Twenty-four percent of the families made arrangements through a crew leader who was employed by a grower. Friends and relatives referred 6.6 percent of the parents to their next job.

Parents generally planned to return to the same areas in which they worked before. FFC parents planned either to stay in Florida or to go such States as Delaware, Indiana, Kentucky, Michigan, New Mexico, North Carolina, Ohio, and Texas. ECMP families planned to migrate to the same States, as well as Virginia. The majority of TMC families leaving Texas planned to relocate in California, Idaho, Michigan, North Carolina, and South Carolina. California and New Mexico were the destinations of the MOP families who planned to move. CUI parents planned to move within California or go north to Washington.

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[40] The majority of respondents to the interview were women who may not have yet known of their husbands' intent to move this year or were reluctant to respond that they would be moving for fear of losing eligibility status for center programs.

D. PREVIOUS EXPOSURE TO HEAD START AND OTHER CHILD CARE PROGRAMS

According to the parents interviewed, 27 percent of the children attending home base programs had been previously enrolled in a preschool or child care program. The highest proportions of these children were found at TMC and ECMP sites where 40 and 39 percent respectively had prior program experience.

Approximately 70 percent of those with previous exposure had most recently attended a Migrant Head Start program. This was true for all of the children at CUI and MOP and for 81 percent of the children at ECMP and 80 percent of those at TMC sites. Overall, only 4 percent of the children who had been enrolled in a previous program attended regular Head Start Centers. Fifteen percent had attended day care centers and 4 percent of these children had been cared for in nurseries.

More than three out of four of the programs previously attended by the MHS enrollees sampled were designed especially for migrant children. All children from CUI and MOP, 91 percent of those from TMC, and 88 percent of ECMP's children attended such programs. In contrast, 58 percent of FFC children and only 14 percent of the children at the two SWGA centers had previously attended migrant programs.

Among the children who previously had attended programs, 75 percent spent from five to eight hours a day in the program. Another 23 percent attended for more than eight hours. Six percent spent less than four hours a day in the program. Nearly all of these programs operated five days a week.

Sixty-four percent of the children who had attended another program spent less than three months in that program; 23 percent stayed from four to six months; and 14 percent attended for more than six months. Payment for these programs was not required for most (86 percent) of the parents. Twenty-five percent of the FFC parents, 15 percent of those with children in ECMP programs, and 14 percent of SWGA parents reported paying to send their children to the programs they had attended before entering programs supported by these grantees.

E. INVOLVEMENT IN CURRENT PROGRAMS

1. General Information

a. Previous Care

Parents with children enrolled in programs were asked who cared for their children during the daytime hours before they began attending the MHS program. The following table shows their responses to this question.

TABLE 78

PERSONS CARING FOR CHILDREN BEFORE ENROLLMENT AT HOME BASE CENTERS

Person	Percentage of Total
Mother	62.5%
Relative not with family	14.7
Relative with family	5.8
Older sibling	1.1
Father	0.6
Other	14.9
TOTAL	100.0%

b. Enrollment and Attendance Records

Children enrolled in home base programs surveyed during the spring of the 1978-1979 school year had spent, at the time of the interview, an average of 86 days at the center during the current session. They missed an average of slightly over 12 days over the same period. Nine percent of the enrollees were absent for 30 days or more and 1 percent had been enrolled, but never attended. More than 97 percent of the children sampled attended programs five days a week. Half of the ECMP children and 34 percent of the FFC children remained at the center for more than eight hours a day. According to parents, children had been enrolled for an average of almost seven months.

c. Transportation

Twenty-eight percent of the children traveled less than one mile to the center. Forty-one percent lived between one and five miles from the center they attended. Sixteen percent had to be transported from six to ten miles and nearly 14 percent lived more than ten miles from the center they attended. The SWGA children were the most widely scattered. Thirty-five percent traveled from six to ten miles to and from the center each day and 37 percent lived more than ten miles away.

The centers provided transportation for 86 percent of the children sampled. The remainder were taken to the centers either by their parents or the parents of other children attending the same program.

d. Sibling Attendance at MHS Programs

Nearly 20 percent of the families interviewed had more than one child enrolled in the same program, while 32 percent of the families had had another child enrolled in MHS in the past.

2. Parent Contacts with MHS Programs

a. General Indicators

Parents were asked how they had first heard about the program their child was attending. The following table shows their responses to the question.

TABLE 79

HOW PARENTS HEARD ABOUT THE PROGRAM

Method	Percentage of Parents
Heard about it from friends or relatives	54.5%
Contacted by program staff	23.1
Had child enrolled in MHS in the past	8.3
Heard about it through the media	4.7
Other	15.2
TOTAL	100.0%

More than half of the parents heard about the program by word of mouth from friends or relatives. The second largest group consisted of parents whom program staff contacted directly.

Sixty-four percent of the parents interviewed stated they had visited the center where their child was enrolled at least once. During these visits, the subjects discussed most frequently with center staff were:

- How the child was doing in school,
- The health of the child,
- Ways parents might participate in the program, and
- How parents could help the child at home.

Over half of the parents (53.9 percent) had gone to the centers at least once to discuss how their child was doing in school. The health of their child was discussed by 27 percent of the parents. One out of five parents who visited MHS centers had talked with center staff about how they could work with the child at home.

The number of parent visits varied from grantee to grantee and among programs operated by the same grantee. About one half of the parents visited the centers between one and six times. Others visited considerably more often; the parents frequently reported that they combined visits with the transportation of their children to and from the center.

Sixty-five percent of parents interviewed reported that staff had visited them in their home at least once. The majority of these meetings were devoted to discussions on how children were doing in school. Health-related topics were discussed at 27 percent of these meetings in the parents' homes. Parent involvement and social services were less frequently reported as topics of discussion (21 and 4 percent).

Forty-eight percent of the migrant families responded that they received one to three visits from center staff. Another ten percent had been visited between four and six times at home. About two percent of the families reported receiving more than seven visits.

About one half (47 percent) of the migrant families sampled reported they had come to observe activities at the center at least once during the previous month. One third (33.9 percent) of the parents interviewed reported going to the center one to three times in the past month while seven percent reported going four to six times during the same period.

Approximately three fifths of the parents were aware of social gatherings held at the centers such as fiestas or picnics. Thirty-nine percent had attended one or more of these gatherings. The main obstacle for the 29.4 percent of the parents who were unable to attend these activities was transportation. Work hours were cited by an almost equal number of parents as an obstacle. Finding a babysitter was a problem for others who would like to have attended these events.

3. Migrant Family Contacts, Participation, and Service Used

a. Education

As referred to above, 54 percent of the parents went to the centers to discuss their children's performance in school. In addition, 45.3 percent discussed the same subject during home visits. Twenty-six percent of the parents also reported receiving games and other learning materials to use at home. Ninety-five percent of the families receiving learning materials said they used or discussed the materials with their children. Spanish or bilingual literature was offered mostly at the CUI, MOP, and TMC sites. People at other grantee sites were usually given materials written in English.

b. Health

Data on the health histories of children sampled have been drawn from two sources: the child's health records and the parents. The following table shows the percentage of children who had received each of a series of tests which are normally part of the screening process. Data were drawn from the records of children sampled.

TABLE 80

CHILDREN WHO RECEIVED SPECIFIC MEDICAL TESTS

Tests	At Present Site	At Previous Site	Scheduled	Not in Records
	Percentage of Children			
Physical exam	76.7%	10.0%	0.3%	13.0%
Hemoglobin/Hematocrit	73.3%	8.9%	0.3%	17.5%
Dental exam	69.7%	8.3%	0.6%	21.4%
Hearing screening	69.7%	8.3%	0.6%	21.4%
Urinalysis	65.0%	8.1%	0.3%	25.2%
Vision screening	56.4%	8.6%	0.3%	34.7%
TB test*	52.8%	13.9%	0.3%	33.0%
Blood pressure*	50.6%	8.3%	0.3%	40.8%
Development assessment	39.4%	4.4%	0.3%	55.9%
Handicapping	10.6%	1.7%	0.3%	87.4%
Sickle cell test*	10.3%	10.0%	0.3%	79.4%
Lead screening*	8.3%	3.6%	0.3%	87.8%
Stool specimen*	5.6%	2.5%	0.3%	91.7%
Pesticide screening*	0.0%	0.0%	0.3%	99.7%

*Optional test not required by Head Start.

The parents of children in the sample were asked a series of questions on the health care these children had received. 74.2 percent stated that their child had been to a doctor for a check-up during the period he was enrolled in the current MHS program and that this check-up had been provided by the center. In addition, 14.4 percent had received a check-up, but not through the center. This is generally consistent with data from the records which indicate that ten percent of the children sampled had received a check-up before enrolling in the current program.

Child records indicated that 18 percent of all children were medically screened and referred for supplemental screening. Forty percent of these children received hearing tests. Four out of five of the children referred for supplemental medical screening (14.2 percent of the total) received it, according to the records.

Thirteen percent of all children were referred for medical treatment as a result of initial or supplemental screening while 10.3 percent of all children actually were treated. Treatment often involved the prescription of antibiotics for ear infections, fevers, and colds.

Child records indicate that 70 percent of the children sampled received dental examinations while enrolled at home base centers and 8.3 percent at previous locations. Records show that 10.6 percent of the enrollees were referred for additional dental screenings. These supplementary screenings were actually performed for 6.7 percent of the children and usually involved checking for cavities and taking X-rays.

Fourteen percent of the children who received supplemental screenings were referred for dental treatment as a result of initial or supplemental examination, while 10.3 percent were actually treated. Dental treatment included having cavities filled, teeth pulled, or fluoride treatments.

The families of 87 percent of the children who were treated for medical problems did not pay for the treatment. Nine percent of the families paid for all of the treatment and four percent paid for some of their treatment.

The families of 93 percent of the children who were treated for dental problems did not pay for the treatment. Four percent of the families paid for all of the treatment and three percent paid for some of the treatment.

One out of three families reported having some type of health insurance to help defray the cost of medical bills.

Records show that 12 percent of the children sampled had documentation for a handicapping condition in their files. The majority of these children suffered from various physical impairments, including respiratory ailments, otitis (inflammation of the ear), deformities, heart conditions, diabetes, speech impairments, and developmental problems. Eighty-three percent of the children cited as having respiratory problems came from FFC sites. Children diagnosed as having chronic ear problems all were located at ECMP centers.

There was a record of 39.4 percent of the enrollees sampled having received developmental screening at their current programs and another 4.4 percent at previous sites. Further assessment was recommended for 3.9 percent of the children. Most of these children did not require developmental treatment; less than one percent of these children were referred for treatment. One half of those were referred for speech therapy.

Head Start centers are to provide the children with immunizations for DPT, polio, measles, rubella, and mumps. Table 81 shows the immunizations recorded for the children sampled at home base centers.

TABLE 81

IMMUNIZATIONS RECEIVED BY CHILDREN AT HOME BASE CENTERS

Immunization	Percentage at Present Site	Percentage at Previous Site	Percentage Not in Records
DPT	58.3%	37.8%	3.9%
Polio	56.7%	38.5%	4.5%
Measles	36.1%	40.0%	23.9%
Rubella*	45.3%	38.6%	16.1%
Mumps	44.5%	35.0%	20.1%

*Health records indicated that 27 children had contracted rubella and therefore did not require immunizations.

According to parents, 91 percent of the children sampled had received DPT shots, 92 percent had received polio immunizations, and 90 percent had received measles shots.

About 40 percent of the families reported they were informed by someone at the center of the health services that were available in the community. Health Service Advisory Committees provide additional support to families. Two percent of the families belonged to these groups, which help identify the medical needs of the migrant families for center staff.

Slightly more than one half (52 percent) of the parents interviewed said they had spoken with someone from the program about their child's health. The majority of parents reported they had neither discussed their child's health with staff visiting their home, nor received health-related literature from the center.

c. Nutrition

Forty-two percent of the parents said they had discussed their children's diets with center staff. To help them provide balanced meals, 22 percent of the parents received instruction from program staffs on how to buy and cook food. Almost two thirds of the parents were shown menus used at the centers. These menus served as examples of balanced food plans which might be adapted for home use. Twenty-eight percent of the parents said they had joined their children at the center for at least one meal.

Nearly all of the children at Migrant Head Start home base centers (97 percent) ate breakfast and lunch there, according to the parents interviewed. One fifth of these children also had eaten some breakfast at home before coming to the center. Slightly more than ten percent of the enrollees ate dinner at the center. Parents also indicated that 87 percent of the children liked the food served at the centers most of the time. Table 82 shows the percentage of the meals eaten at home and at the centers.

TABLE 82
WHERE CHILDREN EAT THEIR MEALS

Meal	At Home	At Center	At Both Home and Center
Breakfast	2.2%	77.5%	19.4%
Lunch	0.3%	99.2%	-
Dinner	86.4%	11.7%	0.3%

Dietary questionnaires were completed by 47 percent of the children's parents.[41] These questionnaires revealed that 5.8 percent of the children had nutritional problems. Most of these children were underweight or anemic, while a smaller number were overweight or allergic to certain foods.

d. Center Assistance in Locating and Using Social Services

Slightly less than one third of all parents interviewed had received written information from MHS centers outlining the social services available in the community. In most cases, this literature was printed in the primary language of the recipient. A similar number of parents were personally contacted by program staff to determine the families' needs and eligibility for assistance.

Fourteen percent of the families reported that they received help from a center in locating or using a social service program. In this group, half were assisted in locating a social service agency. Other families had been helped with administrative details such as registering for services or completing forms. Seven out of ten of the families who had been helped reported that center staff checked back with them to see whether services were received.

4. Parent Involvement in Center Groups and Programs

Families participated in home base programs by becoming involved in advisory committees, doing volunteer work at the center, or making an item that was used in the program. Twenty-two percent of the families had members serving on a parent advisory group. Three fourths of these people belonged to Parent Advisory Committees. Slightly more than two percent of the families belonged to Health Services Advisory Committees. Membership in other advisory groups was also limited. Another five percent of the parents belonged to other committees

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[41] Twenty-two percent of the center records did not indicate whether dietary questionnaires were completed by the parents.

which were solely for policy planning and fund raising. Parents belonging to advisory groups attended four or five advisory group meetings a month.

A sizable number (32 percent) of the parents volunteered their services at the centers for an average of two and a half days a month. One third of the parents made something which was brought to and used at the center. About five percent of the parents reported working in paid positions at the centers. Almost one half of the paid parents were teacher's aides. One fifth were hired as cooks, and others worked as bus drivers, teachers, and maintenance personnel. Sixty percent of the parents who worked at the centers received job-related training. Training was usually provided by the center staff or grantee specialists.

F. PARENT COMMENTS ON PROGRAMS

Parents sent their children to the centers for two main reasons. The educational activities at the centers attracted many of the parents, who felt their children were being prepared to do well in school. Secondly, working parents thought of the program as a source of child care. The frequency of these and other reasons given by parents for sending their children to the centers is presented in the following table.

TABLE 83
REASONS PARENTS SENT CHILDREN TO CENTERS*

Reason	Percentage of Parents
Program prepares child to do well in school	61.7%
Program cares for child when parent has to work	43.3%
Child likes to go to program	21.7%
Program provides health and dental care for child	16.9%
Someone from program told parent to send child	5.0%
Someone not from program told parent to send child	4.4%
Other	19.2%

*Parents could give more than one reason.

Nearly all of the parents interviewed (99.4 percent) expressed satisfaction with the program. Ninety-three percent of the parents thought that their children enjoyed attending and 5 percent thought the children liked it "sometimes." Slightly less than two percent of the parents said their children were dissatisfied with their programs. Nearly nine out of ten parents believed that their child liked the food served at the program.

The overwhelming majority of the parents (95 percent) were satisfied with the hours that the center cared for their children. Three percent of the families wanted the hours extended. Some preferred that the children be picked up 15 to 30 minutes earlier in the morning, while others wanted the centers to keep their children 15 to 30 minutes later in the afternoon.

G. PARENT EVALUATION OF SPECIFIC PROGRAM GOALS

Parents were asked to indicate whether or not the programs had positive effects on their children in a set of specific areas. Table 84 shows the percentage of parents who believed the programs had specific positive results.

TABLE 84

PARENTS' OPINIONS CONCERNING POSITIVE EFFECTS OF PROGRAMS

Opinion	Percentage of Parents
Child gets along better with others	96.7%
Child feels more sure of him/herself	95.8%
Child know more about personal hygiene	93.6%
Child knows more about letters and words	92.2%
Child speaks better English	88.1%
Child knows more about numbers and arithmetic	84.2%
Child speaks better Spanish	54.7%

The centers' performance in these areas was highly rated by the parents. Nearly all of them noticed improvements in their children's social and personal development, and in their language and arithmetic skills. Eighty-seven percent of the parents of Hispanic children thought that the MHS program helped their children speak better English. A similar number of black and white parents felt that the program improved their child's English. Eighty-five percent of the Hispanic parents said that the program noticeably improved their children's Spanish, while only one out of twenty black and white parents reported that their children were learning Spanish.

H. PARENT SUGGESTIONS FOR IMPROVING THE PROGRAM

In general, parents expressed a high degree of satisfaction with existing programs. Seventy-five percent offered no specific suggestions when asked how program operations could be improved.

Ninety-one of the 360 parents interviewed did offer suggestions on how program operations could be improved. Eighteen percent of these recommendations concerned improvements in MHS facilities. Improvements and the number of times they were suggested included:

- Expanding existing facilities (7),
- Improving existing facilities (3),
- Establishing facilities, and a program, for infants and toddlers (2),
- Improving janitorial services (2), and
- Expanding a playground area (1).

Fourteen percent of the parents making suggestions said that parent participation should be increased. Among the specific suggestions offered were: There should be additional conferences between teachers and parents; more information should be provided by programs; Spanish should be spoken at parent meetings; and more parents should volunteer to help at the centers.

The suggestions of 19 percent of the parents who made specific recommendations focused on educational activities. These suggestions were:

- Hiring better trained, more effective teachers (6),

- Teaching more English in the classroom (5),
- Taking more field trips (2),
- Providing more instruction in Spanish (1),
- Separating age groups (1),
- Providing more learning toys (1),
- Teaching writing skills (1), and
- Providing better classroom supervision (1).

Several suggestions focused on transportation problems. These suggestions were:

- Purchasing new buses or vans (6),
- Establishing regular pick up times for children (5),
- Establishing additional bus stops closer to the child's home (3), and
- Hiring more bus aides to attend to children being transported (2).

Seven percent of the parents making suggestions wanted centers to extend their hours; approximately half wanted centers to open earlier and half wanted them to remain open longer. Nine percent stated that centers should provide more food or food of a higher quality for their enrollees.

VI. FINDINGS: MEASURES OF SPECIAL USER NEEDS AND PROGRAM RESPONSES TO THESE NEEDS

This report begins with the statement that Migrant Head Start programs exist to serve a specific population: children of itinerant farm laborers with incomes at or below the poverty level. These children and their families have special, acute needs. Migrant Head Start centers must act to meet a number of pressing, interconnected needs simultaneously if the programs are to help migrant children in measurable and lasting ways.

Measurements were made of four elements determined to be critical to program success, based on the special characteristics and needs of the migrant programs' target population:

- Continuity in services provided by Migrant Head Start centers;
- Parent involvement in activities at the centers, and center efforts to promote involvement;
- Bilingual/multicultural activities at centers, and center efforts to provide a bilingual/multicultural learning environment; and
- Modifications in program operations to adapt service delivery to the special target population.

These four elements are discussed below using the data presented in Sections IV and V. Those sections were organized by source, while this section, which integrates the data regardless of source, is organized by topic.

A. CONTINUITY

The lives of itinerant farmworkers are often marked by pervasive, sometimes disorienting discontinuities. There is discontinuity in the home and community lives of these people due to continual relocations. There is discontinuity in employment and family income. There is discontinuity in the assistance families receive from social service agencies responsible for helping them. As a result, attendance of migrant children in educational programs is often sporadic. This factor is recognized as a major cause of failure in the classroom.[41]

The goal of Head Start is to introduce preschool children to a classroom environment and help them gain a general sense of competence and confidence in their ability to perform in this environment. However, Head Start research studies have found that if the child is not regularly exposed to the learning activities offered by preschool programs--and the supportive nutrition program, medical and dental care, and other assistance provided by programs--it is not likely that the child will be helped in any measurable way.[42]

Migrant Head Start staff are responsible for locating migrant children, getting them into programs, and working to keep them in.

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[41] One study says this about the effects of discontinuities on migrant children: "These children become 'immature little drifters' who, without anyone to relate to, fail to come to grips with many areas of existence." Research Problems and Issues in the Area of Socialization. The Social Research Group, George Washington University, 1972, p. 38.

[42] Head Start studies have shown that exposure to eight-week programs fails to produce measurable gains in the cognitive development of the child, while eight-month programs produce positive changes in IQ and general aptitude test scores. See A Review of Head Start Research Since 1969 and an Annotated Bibliography. DHEW Publication No. (OHDS) 78-31102, pp. 5-8, 20-28.

These staff are also to help children make the transition to the public school system and assist their families in identifying and gaining access to other social services which they require.

The dimensions of continuity in the lives of program users, and in service delivery activities at Migrant Head Start centers, are discussed in the following sections.

1. Measures of Continuity in the Lives of Enrollees and Their Families

a. Continuity of Place

By definition, migrant farmworkers move from place to place to engage in agriculture-related work. Preestablished routes are sometimes followed on an annual basis; in other cases, movement is sporadic, varying from year to year and season to season.

Among families interviewed in the home base study, 61 percent responded that at least one member had relocated during the past 12 months. As Table 85 demonstrates, there is considerable variation across grantees in the percentage of families who responded that they lived in different places during the past year.

TABLE 85

PERCENTAGES OF FAMILIES WHO RELOCATED DURING THE PAST 12 MONTHS*

Grantee	According to Families	According to Center Records***
ECMP	85.0%	91.0%
TMC**	60.0%	74.4%
FFC**	32.1%	25.9%
CUI	20.0%	12.0%
MOP	17.8%	55.6%
SWGA**	7.7%	1.9%
TOTAL	42.8%	49.4%

*Does not include temporary overnight farmwork in other counties.

**Other resources (e.g., Title XX, regular Head Start) fund children in centers with IMPD-funded children. Percentages are based on the total enrollment at centers, regardless of funding sources.

***The percentages of children for which this information was not in the records follow: ECMP, 6.0%; TMC, 23.3%; FFC, 46.9%, CUI, 68.0%, MOP, 2.2%, and SWGA 88.5%.

The low percentages of families living in different places during the past year can be explained in part by the availability of seasonal farmwork in a grantee's area. Another partial explanation may be that respondents were reluctant to admit that their families had relocated because they feared not meeting residency requirements for eligibility in other programs. Only three percent of the respondents did not respond.

Home base families who had relocated during the past 12 months had usually moved twice during this period. Seventy-five percent of these families migrated from State to State; 25 percent moved from one place to another within the same State. Interstate migrants usually remained within one of the three major migrant streams. Only four percent of the families who migrated crossed from one major stream to another.

TABLE 86

INTRASTATE AND INTERSTATE MOVEMENT OF MIGRANT FAMILIES

Grantee	Intrastate Only	Interstate Within One Stream	Interstate Across Streams
FFC (N=37)	19.0%	65.0%	16.0%
ECMP(N=82)	10.0%	88.0%	2.0%
SWGA (N=2)	50.0%	50.0%	-
TMC (N=77)	38.4%	60.6%	1.0%
MOP (N=8)	12.5%	87.5%	-
CUI (N=9)	78.0%	22.0%	-
TOTAL (N=215)	25.0%	71.0%	4 0%

These moves were to 29 States and to Mexico. Families from the Florida Farmworkers Council reported having moved to Alabama, Alaska, Arkansas, California, Colorado, Georgia, Illinois, Indiana, Maryland, Michigan, New York, North Carolina, Ohio, South Carolina, Texas, and Mexico.

Families from the other home base grantee in Florida, ECMP, listed California, Colorado, Delaware, Georgia, Indiana, Kentucky, Michigan, New Jersey, New York, North Carolina, Ohio, South Carolina, Texas, and Virginia as the States outside of Florida where they engaged in agricultural work.

Kentucky was the only State outside of Georgia where families sampled from the centers operated by SWGA stayed during the past 12 months.

Families from TMC moved to California, Colorado, Idaho, Illinois, Michigan, Minnesota, Montana, North Dakota, Ohio, Pennsylvania, Washington, Wisconsin, and Wyoming.

Moves to California and intrastate moves within Arizona were reported by MOP's families. CUI's families who left California reported moves to Arizona and Washington.

A little over half of the families interviewed (53.9 percent) indicated that they stay in the same area during the winter months each year. For all but eight of these families, the home base location of the families corresponded with the place where they were interviewed. Families with home bases in Ohio, Georgia, New Jersey, and Michigan, and two families from Texas, were interviewed in Florida. A family from Ohio and another from Florida were interviewed in Texas.

Approximately 36 percent of all families interviewed owned a permanent house in their home base area. The rest rented their homes. (See Table 87.)

TABLE 87
OWNERS OF THE HOMES OF FAMILIES INTERVIEWED

Owners	Percentage of Families Interviewed
Individual or company	44.4%
Respondent	36.4
Public housing	10.8
Employer	5.6
Don't know	2.8
TOTAL	100.0%

Forty-four percent of the parents sampled said they had lived at their current location less than one year. Forty-three percent said they were planning to move again this year to look for work; 19 percent said that the family would not move but that at least one family member would; another ten percent were uncertain about whether they would move or not.

2. Continuity of Enrollees' Preschool Program Experience

a. Past Exposure

It is important for the staff at Migrant Head Start home base centers to know whether a child enrolling in the program has gone to an organized preschool program in the past. If the child has been exposed to an organized preschool program in the past, there should be a set of medical and dental records that indicate which immunizations, health related screening, diagnoses, and treatment the child has received. There should also be a record of the child's educational experiences.

In these cases, the center needs to obtain these records and use them to develop an individualized plan for helping the child.

Data on the children's previous Head Start experience were collected from three sources -- center directors, children's records, and parents. Center directors reported that 39 percent of the children had previous Head Start experience, while parents said that only 21 percent of their children had attended a Head Start program in the past. According to center records, 34 percent of the children had had Migrant Head Start experience specifically. (See Table 88.)

TABLE 88

CHILDREN WITH PREVIOUS HEAD START EXPERIENCE

Grantee	Head Start Experience According to Center Directors	Head Start or Child Care Experience According to Parents	MHS Experience According to Records
FFC	21.2%	24.7%	27.2%
ECMP	44.1%	38.8%	71.6%
SWGA	1.8%	13.5%	17.3%
TMC	47.8%	40.0%	40.0%
MOP	57.5%	11.1%	13.3%
CUI	43.2%	8.0%	--
TOTAL	39.3%	26.7%	33.6%

For more than two thirds of the children sampled, their current experience with Migrant Head Start is their first encounter with organized day care of any type. Of those children sampled who had attended child care programs in the past, parents indicated that slightly more than 70 percent had most recently attended another Migrant Head Start center. Less than five percent had attended either a regular Head Start or nursery facility most recently; the remaining children had attended other day care programs.

While many of these previous programs cited were in the parents' home base State, a total of 16 destination area States were mentioned by 15 percent of all families, indicating that in many cases the users of Migrant Head Start home base programs had previous exposure to Head Start programs while traveling in the migrant stream.

Most of the children who attended these programs were exposed to them for at least five hours a day. Only six percent attended for less than five hours a day, while almost one quarter attended them for more than eight hours a day.

Children sampled attended their most recent programs for five days a week in 96 percent of the cases. Sixty four percent of this group had attended for up to three months, with an overall average of 4.8 months.

b. Exposure to the Program Now Attended

Day-to-day continuity in exposure to services at programs attended at the time of the survey needs to be viewed along with continuity between programs. Erratic attendance seriously reduces the likelihood that the programs will have positive, enduring effects.

The children sampled at the time of the interview had been enrolled in programs an average of 87 school days according to records. During this period, these children were absent an average of 12 days. According to parents, their children had been enrolled for an average of seven months.

Four fifths of the children sampled spent between five and eight hours each day at the centers. The remaining one fifth were at the programs for more than eight hours daily. Nearly one half of the children from ECMP sites were in the latter category.

Of the children sampled, 97.5 percent normally attended Migrant Head Start home base centers five days a week.

Three fifths of the children sampled had been enrolled in Migrant Head Start home base programs for between three and six months, according to records, indicating that most of the children would have enough exposure to the program to be able to receive services. The programs averaged approximately eight months in length of operation.

c. Sibling Involvement in the Program

The involvement of a brother or sister in the same program adds a significant element of continuity to the experience of a MHS enrollee. Approximately one out of five children sampled had a brother or sister enrolled in the same program.

Another element of continuity in the relationship between programs and the families served is the previous experience of the family with the program. Nearly one third of the families sampled had one or more of their children enrolled in the same program in the past.

3. Measures of Continuity and Efforts to Promote Continuity in Program Delivery Systems

A discussion of the continuity of service delivery to migrant children must address the continuity of operations of the centers themselves. Thirty-six centers had operated at their current location for more than one year, and more than half were located in the same facility for at least four years.

A typical home base center was open from October to May, offering approximately 152 days of service. The typical center operated for almost nine hours a day, five days a week.

a. Continuity in Migrant Head Start and Related Preschool Experience of Staff

Having the same staff work from year to year at program sites is one of the most critical elements of continuity in providing services to migrant children through Migrant Head Start. Staff members familiar with a family's particular situation have a more complete understanding of the child's behavior and can therefore base their own goals and objectives for the child on firmer ground. Unfortunately, maintaining the same staff from year to year is difficult to accomplish. Since most of the program staff is relatively young (under 30 years old), new opportunities are quickly taken when they arise. Probably the primary source of discontent of employees at Migrant Head Start home base centers is the wages staff receive. This theme will be explored more thoroughly in the Final Report. The following table shows the average months of MHS and related experience of key staff at the 43 sites surveyed.

TABLE 89

AVERAGE LENGTH (IN MONTHS) OF EMPLOYMENT
OF MHS HOME BASE STAFF IN CURRENT AND RELATED JOBS

Staff	Current Position	Other MHS Centers	Other Preschools
Center Director	46	36	8
Head Teacher	30	11	17
Health Administrator	31	17	13
Food Manager	53	11	12
Social Service Provider	52	25	14
Parent Involvement Coordinator	29	14	4
All Positions	40	19	11

Center directors, food managers, and social service providers are the staff members who had worked longest in their current positions at Migrant Head Start home base centers. Head teachers, health administrators, and parent involvement coordinators had accumulated less time in their current positions. The fact that these particular staff members had considerably less experience in their current jobs than center directors, food managers, and social service providers may be significant, however, since their jobs involve considerable contact with parents and families.

b. Interaction between Centers and the Public School System

Continuity between Migrant Head Start centers and public school systems implies an ongoing relationship between the two. This relationship takes various forms, ranging from assistance rendered to the Migrant Head Start home base centers by the public schools to the steps taken by Migrant Head Start to assist children when they enter the public school system.

It is important for home base centers to establish a good rapport with the local school system since there are often equipment and other resources which the Migrant Head Start centers may not be able to afford with their limited budgets that can be made available through the public schools. The survey of home base programs indicated that more than one half of the centers received some type of assistance (mainly use of equipment) from the local public schools.

The transition to public schools can be difficult for parents and children who have had limited experience with non-migrant programs. All but four centers took some steps to assist their children to make the transition between Migrant Head Start and the public schools. Most of this assistance consisted of transferring education and health records to the public schools and meetings with parents of children entering the public schools.

c. Transfer of Health and Education Records between Migrant Head Start and Other Preschool Programs

In order to provide continuous educational and support services to migrant children, it is necessary to transfer a child's records from programs previously attended to his or her current school. Ideally, the records will be available to the staff at the time the child enrolls in a new program. Three methods of records transfer stand out as the most frequently employed: (1) records are sent with parents, (2) records are sent to programs that request them, and (3) the automated Migrant Student Record Transfer System (MSRTS) in Little Rock, Arkansas, is used.

Only five centers reported that they usually do not transfer records. Three quarters of the sites reported giving a copy of the child's records to parents. One fourth of the programs reported that they forward copies of the child's records when requested by other programs. Almost 40 percent of the centers said they used the MSRTS as a means of transferring records.

Record transfer is effective only if the receipt of the records by the current program is timely. Nearly one half (44 percent) of the center directors reported that they received the health and education records of children with previous Head Start experience within two weeks of enrollment. Records from non-Head Start programs arrived within two weeks at 33 percent of the centers surveyed according to center directors.

Health administrators concurred with center directors that records were transferred from other Head Start centers to 44 percent of the home base centers and to one third of the centers from non-Head Start programs.

Actual record reviews, however, indicated that there may be considerably fewer records being transferred than indicated by health administrators or center directors.

When asked the reasons why records are not always transferred, health administrators at home base centers most frequently cited the fact that the child's parents do not remember where their child was previously enrolled.

d. Assisting Parents Leaving the Area to Enroll Their Child in Another Location

Migrant Head Start centers are to assist parents leaving the home base areas by providing them with information about services in the area into which they are moving. Most centers reported that this assistance is provided. This type of activity is important to providing continuous services; it follows the Performance Standards, which state that the child's family should be provided with the necessary information to find and make use of services at new locations after they have left their current MHS centers.

Providing appropriate information to migrant families is not simple. First, the center staff need to be aware of the family's date of departure and where they are going. Often, families are not sure of their destinations when they leave a home base area. Even if they are, they do not necessarily tell the program staff when they are leaving. Whenever possible, program staff at 35 centers provided information on the location of programs (Migrant Head Start and regular Head Start), staff persons to be contacted, schedules for the new programs, and how to sign up.

4. Measures of Program Efforts to Provide a Continuum of Services to Migrant Children and Families

MHS staff are to assess the overall social service needs of families of all children enrolled in programs. Based on this needs assessment, they are to develop individualized service plans to meet the needs identified in the initial assessment.

Plans for service delivery to migrant families must be updated frequently since their needs are often closely linked with work conditions and vary greatly over short periods of time. Service delivery through MHS centers generally involves the program's social service provider. This person is to assist families in their efforts to improve the conditions and quality of family life, make parents aware of community services and resources, and facilitate their use of these services and resources.

The social service provider accomplishes these objectives in various ways. First, as mentioned above, frequent contacts with families of children enrolled are necessary. Distributing written information on the social services located in the area and referring families to these agencies also contributes to providing a continuum of services for the families. Follow-up on referrals and promotion of interagency collaboration are other steps to be taken to enhance the number and quality of services received.

a. Staff Contacts with Families

Before a social service plan for a family can be drawn up, its needs must be assessed. For parents of MHS children, this implies, at a minimum, some contact between them and a staff member to determine the family's requirements and eligibility for services.

Nearly 80 percent of the social service providers surveyed said that someone from their center "always" or "usually" tried to determine the social service needs of the family of each child enrolled. Based on this needs assessment, a family plan was developed at 40 percent of the home base centers to help the parents meet their requirements.

Home base centers rely on more than one method of determining the social service needs of their families. For example, all but five programs reported making visits to the parents' home for this purpose. Interviews with parents were held at the center at slightly more than one half (55 percent) of the programs. Information on enrollment forms and from questionnaires sent home was also used to determine a family's social service needs.

Interviews with parents revealed a slightly different picture of social service delivery to families with children enrolled in home base areas. Less than one third of the families sampled reported being contacted by the program about their family's needs. With regard to direct assistance from the program, 11.7 percent of the families sampled actually received help in looking for or finding social services in their area. This assistance included locating agencies, help in filling out forms, and providing transportation.

The data indicate that staff members are seeking out families in order to perform a needs assessment, but relatively few families are actually assisted in receiving services.

b. Dissemination of Written Information

Social service providers at more than one half (53.5 percent) of the MHS home base programs reported that they "always" or "usually" distribute a list of social services available in the community to the families of their children. Usually these lists were written in both English and Spanish.

A little less than one third (30.6 percent) of the parents sampled reported receiving written information from the programs regarding social services.

c. Referral Agencies Available to and Used by Centers

In order to evaluate the extent to which social service agencies are being utilized in an area, it is necessary to determine which agencies and services are available. The following table depicts which agencies and services are available and whether they are used or not for all 43 MHS home base centers.

TABLE 90

AVAILABILITY TO AND USE BY HOME BASE CENTERS OF COMMUNITY RESOURCES

Community Resource	Not Available		Available But Not Used		Available and Used		Don't Know		No Response		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Comprehensive community health centers	8	18.6	2	4.7	32	74.4	1	2.3	-	-	43	100.0
Medical laboratory services	13	30.2	7	16.3	22	51.2	1	2.3	-	-	43	100.0
Armed forces medical facilities	34	79.1	4	9.3	1	2.3	3	7.0	1	2.3	43	100.0
Public health clinics	1	2.3	1	2.3	41	95.3	-	-	-	-	43	100.0
Migrant health centers	14	32.6	-	-	27	62.8	1	2.3	1	2.3	43	100.0
Mental health clinics	9	20.9	10	23.3	23	53.5	-	-	1	2.3	43	100.0
Child guidance clinics	19	44.2	6	14.0	12	27.9	4	9.3	2	4.6	43	100.0
Psychological services	12	27.9	8	18.6	20	46.5	1	2.3	2	4.6	43	100.0
Family counseling services	7	16.3	10	23.3	24	55.8	1	2.3	1	2.3	43	100.0
Family planning services	4	9.3	6	14.0	32	74.4	-	-	1	2.3	43	100.0
Other family and child services	9	20.9	7	16.3	22	51.2	1	2.3	4	9.3	43	100.0
Nutrition services	6	14.0	2	4.7	33	76.6	-	-	2	4.6	43	100.0
Work training	5	11.6	4	9.3	32	74.4	-	-	2	4.6	43	100.0

As Table 90 demonstrates, the most widely available and used social services, according to social service providers, are public health clinics, nutrition services, comprehensive community health centers, family planning services, and work training. The most widely available community resources not used by MHS home base centers are mental health clinics and family counseling services. Child guidance clinics, migrant health centers, and armed forces medical facilities are the least available community resources. It is interesting to note that migrant health centers were the only community resource used wherever they were available.

d. Frequency of Follow-Up by MHS Staff

Follow-up on referrals made is the most direct way of determining whether a family's use of a social service agency has satisfied the family's needs at the time. Social service providers at the centers, according to the Head Start Performance Standards, should follow up to assure delivery of needed assistance. Persons responsible for this component at nearly 80 percent of the centers reported that they "usually" or "always" followed up to determine whether the families get the services.

On the parent side, when asked if anyone from the center had checked back to see whether the family had received the services, 71 percent of the families who had received some aid from the center responded affirmatively.

e. Methods Used to Promote Interagency Collaboration in Support of Children and Families

Service delivery to migrant families must be well coordinated among the various agencies providing services if the varied and fluctuating requirements of the families are to be met. Information sharing is crucial to developing a network of agencies that are aware of the local MHS program and the needs of the families that are referred.

Most centers (81.4 percent), according to social service providers, exchange information with other social service agencies in the area. Centers often had informal telephone contact with various agencies and traded lists of information from time to time. Six centers secured formal, written commitments to provide services.

Periodic meetings with staff members of other agencies were reported at three fifths of the centers by social service providers. Another three fifths of the centers reported sharing responsibilities for some activities with other agencies. Only 14 percent of the centers, however, have signed letters of intent pledging cooperation with other agencies, indicating that relationships between the centers and other agencies are generally informal.

5. Social Service Programs Currently Being Used by Families

The ultimate measure of continuity in service delivery is whether or not the MHS home base programs are able to identify the needs of eligible families and ensure that services are in fact being delivered to them. Continuity in the use of social services across programs indicates that diverse needs are being met through the use of several agencies.

Slightly more than one half of the families sampled (51.4 percent) reported that they were receiving some type of assistance. Food stamps were most commonly used with nearly 40 percent of the families receiving them. Women, Infants, and Children (WIC) benefits were being used by 10.8 percent of the families; 7.2 percent were receiving Medicaid; 6.4 percent were receiving Aid to Families with Dependent Children (AFDC); and 2.2 percent were receiving Supplemental Security Income (SSI).

Outreach in the social services area is a very labor-intensive undertaking. Performing home visits, talking with parents, and assisting them in signing up with agencies are time-consuming. This situation is complicated by the fact that many centers do not have a specialist to assume these responsibilities. And even when such a position exists, the social service specialist is often likely also to have parent involvement responsibilities.

B. PARENT INVOLVEMENT

Past Head Start studies show that when parents are involved in program activities, their children do better on standardized tests than children whose parents do not participate in program activities. This has been demonstrated by comparing the results of tests which measure cognitive development and tests which measure the child's sense of competence and the way the child sees himself as a participant in center learning activities.[43]

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[43] For summaries of the results of recent studies correlating high levels of parent involvement in Head Start programs with positive results on tests measuring the Head Start child's socialization level and self-concept development, see A Review of Head Start Research Since 1969, and an Annotated Bibliography, Social Research Group, The George Washington University, 1977, pp. 9, 30-33. Recent studies also reveal significant secondary benefits of high levels of parent involvement in program activities. Among these benefits are (1) improvement of parenting abilities, (2) an increase in positive interactions between mothers and their children, and (3) greater interest and satisfaction on the part of parents in the educational gains of their children. See Ibid., pp. 13-15, 40-43.

Studies of the Hispanic family emphasize its especially close-knit nature and the strong affective bonds between parents and child.[44] These observations suggest that is especially important to effectively involve Hispanic parents in Head Start program activities.

However, a number of factors associated with migrant life discourage parent involvement. Among the most prominent are frequent family relocations, the resulting disruption of community life, the long, irregular working hours of parents, and language and cultural barriers. For these reasons Head Start standards and IMPD Guidelines state that programs are to develop special strategies and techniques to involve parents in program activities.

1. General Indicators of Parental Involvement in Home Base Center Activities

The degree to which parents become involved in MHS program activities depends on a variety of factors, some of which are particular to the lifestyle of the migrant family. Stimulating parental involvement in the centers' educational programs is especially difficult for families working long hours.

Three levels of participation by parents in program activities were measured in this study: (1) general contact with programs, (2) involvement in advisory groups, and (3) working at centers. The indicators of involvement at each level are discussed below along with the specific techniques programs used to achieve parental involvement.

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[44] Research Problems and Issues in the Area of Socialization, Social Research Group, The George Washington University, 1972, p. 51.

a. Parental Contacts with the Centers

Contacts between staff and parents take place mainly either at the centers or at the parents' homes. Of the families sampled, approximately 62 percent reported having been to the centers to speak with someone there. Sixty-five percent of the families sampled said they were visited by staff at their homes. Meetings either at the center or the families' homes accounted for 87 percent of contacts mentioned. Regardless of location, the topic usually discussed was the performance of the child in school.

A number of parents also reported having gone to centers to observe the activities of their children in the classroom. These parents accounted for 47 percent of the families sampled. One third of these parents had gone to the center to observe more than twice during the month preceding the survey.

b. Parental Involvement in Advisory Groups

Active participation by parents is to be encouraged in formulating the policies and procedures that affect MHS centers. Advisory committees are to provide the mechanism for this involvement. According to parent involvement coordinators, 663 parents participated in advisory groups, the majority of whom (82 percent) were active in Parent Advisory Committees (PACs). An average of 15 parents at each center was involved in advisory group activities.

Only 17 percent of the families interviewed indicated that they were active in advisory groups. Of those that did, however, three quarters were members of the PACs.

c. Parents Working at Centers

Daily contact with MHS programs by parents is the highest degree of parent involvement that can be achieved. One way to get parents involved to this extent is for programs to fund staff positions for parents. This strategy was used by 15 MHS home base centers which funded a total of 35 such positions. This means that five percent of paid staff were parents. Most (31) of these positions were full-time; four were part-time.

Slightly more than three fifths (61.3 percent) of the parents in full-time positions at MHS home base centers were teacher's aides. The remaining positions were filled by parents working as health aides, cooks, bus drivers, and custodians.

Parent involvement coordinators reported that 234 parents did volunteer work at MHS home base programs. Almost one half (46.2 percent) of the parent volunteers were teacher's aides. The others worked as social service/parent involvement aides, clerical aides, and health aides.

According to the parents interviewed, five percent were employed at the programs. Those employed reported having the same positions the parent involvement coordinators reported. Almost one third of the parents (31.7 percent) reported volunteering at the centers.

d. Parent Knowledge of and Attendance at Social Events Held at Centers

Social gatherings are often used by MHS home base centers as a method of getting parents into the centers where they can then meet their children's teachers and other parents. More than three quarters (76.7 percent) of the centers reported that they sponsored social gatherings. These gatherings were held at least monthly at 60 percent of the centers which sponsored such gatherings. They were often held in conjunction with PAC meetings. According to parent involvement coordinators, these events are fairly well attended; over one third of the centers sponsoring these functions reported more than 20 participants.

Sixty percent of the families sampled indicated that they were aware of social hours, picnics, or parties for families at the centers. Approximately 39 percent of the families said that they had attended these functions.

e. Steps Taken to Involve Parents in Center Activities

Innovative techniques are to be used to achieve effective parent involvement, especially during the work season, according to IMPD Guidelines for Migrant Head Start programs. The most frequently used method to increase parent involvement was a note or letter sent home with the child and home visits. The following table lists the various methods of stimulating parent involvement used by centers and indicates the number of parents reached by each method as estimated by parent involvement specialists at the centers.

TABLE 91

METHODS USED TO STIMULATE PARENT INVOLVEMENT

Method	Number of Parents Informed
Note or letter sent home with child	1,191
Home visits	983
Newsletters	855
Community meetings	485
Newspaper, radio, or TV announcements	251
Other	337

Parents who are informed of activities at the center do not necessarily participate. About one quarter (27.5 percent) of the parents interviewed reported problems in getting to the centers to participate. Conflicts with working hours and the need for a babysitter were the obstacles to involvement mentioned most frequently.

f. Parent Training Delivered by Centers

Head Start Performance Standards state that programs' parent involvement plans should include health, mental health, dental, and nutrition education. A total of 240 hours of parent training was offered at the 43 sites during the month preceding the survey. About one third of this training (32.5 percent) dealt with child development and education topics. Health and nutrition education comprised the remainder.

According to parent involvement coordinators, 262 parents received training at MHS home base centers during the month preceding the survey.

Parents also receive training through the centers when they are employed there. One third of the parents sampled who worked at home base programs indicated that they had received job-related training.

2. Measures of Parent Involvement in Classroom Activities

a. Direct Involvement in Classroom Activities

One of the most direct ways parents can participate in their children's education is to become involved in classroom activities. Parents can do this by working at the center as a teacher or teacher's aide, volunteering to help in the classroom, observing classroom activities, or sending materials from home for use in the classroom.

One third of MHS home base centers (32.5 percent) reported that at least one parent was being paid to work in their classrooms. Parent volunteers were working in classrooms at more than one half (53 percent) of home base programs. Head teachers also reported that at more than one half of the centers parents had come to observe classroom activities during the month preceding the survey. Parents also helped from home by making something to be used in the classroom at 22 of the centers during the same 30-day period.

b. Contacts between Parents and Teaching Staff

All head teachers at MHS home base programs reported they followed the practice of meeting individually with parents. Overall, 65 percent of the families had been contacted individually by a head teacher. Table 92 shows the mean number of parents per center teachers had contacted and the percentage of all families met by grantee, according to the head teachers and parents.

TABLE 92

FAMILIES WITH WHOM TEACHERS MET INDIVIDUALLY AS PERCENTAGES OF ALL FAMILIES

Grantee	Mean Number of Families Per Center	Percentage of All Families According to Head Teachers	Percentage of All Families According to Parents
FFC	37.3	88.6%	71.6%
ECMP	30.8	61.6%	62.7%
SWGA	24.5	42.6%	86.5%
TMC	42.3	56.7%	63.3%
MOP	82.0	74.5%	55.6%
CUI	35.0	92.1%	100.0%
TOTAL	39.3	65.1%	70.0%

Two thirds of the home base programs reported that meetings with parents occurred on a daily basis. All but four centers conducted meetings with parents at least monthly. These meetings were conducted at the center for 25 programs. Both the center and the parents' home were cited as the location of parent-teacher meetings at 16 centers. The remaining two centers reported holding these meetings in the parents' homes.

At 39 sites parents were contacted if their child missed three consecutive days of school.

c. Learning Materials Sent Home

Head Start takes a holistic view that education is an ongoing experience that should not be confined to the four walls of the classroom. Indeed, the Performance Standards require that programs support and enhance the parental role as the principal influence in their child's education and development by viewing the parent as the prime educator of their children.

To accomplish this, programs are encouraged to send learning materials home for use by the parents and children. Learning materials sent to a parent's home may be used in two different contexts. The first is the home-based option to Head Start which uses parents to guide the education and development of their own child--using their home exclusively as the educational environment--with Head Start staff providing guidance periodically through home visits. Twelve MHS home base programs had home-based programs of this kind.

Learning materials may also be sent home for use by the parents and child in situations where the center is the central learning context. These materials are intended to be a supplement to classroom activities.

Twenty-six (60.5 percent) home base programs sent materials to the homes of children enrolled. On the other hand, 71.9 percent of the parents reported that no materials were sent home. Learning materials were delivered by bus drivers at 11 centers. They were sent home with the child at five centers and brought by a teacher visiting the parents' home at five centers. Learning materials were usually written in both English and Spanish. They were in English only at eight centers and Spanish only at three others. When learning materials were not sent into the home, it was usually because there were no materials on hand at the centers to be used for this purpose.

3. Measures of Parent Involvement in Health Services Delivery

a. Introduction to the Program and Parental Consent

Migrant parents should be aware of the health services delivered to their children. Programs are required to explain the health services available and to obtain parental consent before providing services.

All but four MHS home base centers reported that they explain their health programs to all parents when children are enrolled. The other four said that most parents received explanations.

Only one center reported that parental consent was not always obtained for all health services provided to children. Four percent of the children sampled did not have signed parent/guardian authorizations for health services provided by or arranged through MHS home base centers in their records.

b. Health Services Advisory Committee Participation

The Head Start Performance Standards provide for the creation of a Health Services Advisory Committee (HSAC) which is to participate in the planning, operation, and evaluation of the health services programs. Parents are usually joined on the HSACs by center staff and health service providers in the community.

According to health administrators, nearly one third (30.2 percent) of MHS home base programs have a Health Services Advisory Committee.[45] Parents comprised one fifth of all members.

A little over one percent of the parents interviewed reported that they were HSAC members. A typical parent member had attended one meeting at the time of the survey.

c. Health Education Activities for Parents

Health education programs at MHS centers should, among other things, inform parents of the health resources available in their communities and encourage parents to become involved in the health care process relating to their child.

Health service providers at MHS home base centers were specifically asked what methods were used to educate parents in the health services area. Three fifths of the centers reported conducting lectures and discussion groups on health education. No health education meetings were held in the month preceding the survey at one half of the MHS home base centers. Fifteen centers had held one meeting during the month and seven had held two or more sessions. Twenty percent of the programs reported that they had not held any health education meetings for parents at MHS home base programs since the current session began.

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[45] It should be noted that the Performance Standards also state that existing committees may be modified or combined to carry out the functions of HSACs.

Visits to parents' homes and the distribution of printed materials each were part of the health education program at approximately one half of the centers.

d. Measures of Parent Knowledge of Health Services Delivery

Parents of children enrolled in MHS home base programs receive letters and notes to sign authorizing their child's participation in various activities such as field trips and health-related services. Requests are frequent and parents may not always recall what they have authorized.

Almost 90 percent of the parents interviewed reported that their child had been to see a doctor for a check-up. Of these, 83.7 percent were performed through the MHS program. A little more than 90 percent of the children sampled had received diphtheria and measles immunizations. The same percentage had received polio vaccines, according to parents.

While records indicated that 70 percent of the children had received a dental examination while enrolled in home base programs, only 58 percent of the parents reported that their children had been to the dentist for an examination since enrolling in the current program. Parents reported that almost one half (49 percent) of their children had received examinations through the MHS programs. Nearly one third (32.2 percent) of the children sampled had also received dental treatment through the programs according to parents. Records at the centers, however, indicated that only 17 percent of the children enrolled had actually received treatment.

e. Parent Reports on Health-Related Contacts with Staff

The most personal way in which MHS staff can relay information on health-related matters is by speaking directly with parents. This avoids any possibility that the parents may not receive a note or letter sent home with a child or a list of health-related resources in the community sent by mail.

When asked if they had spoken to someone at the center about their child's health, over half (52.2 percent) of the parents of children sampled said they had. Only 39.2 percent of the families sampled reported that they had spoken to someone at the center about health services in the community that the family could use. Sixteen percent of the families said that their child had a health problem that they would like to talk to someone at the center about.

4. Measures of Parent Involvement in Delivery of Nutritional Services

a. Program- and Staff-Originated Data

Food managers (usually cooks) reported that at 19 of the 43 MHS home base programs parents have some influence on the types of food that are served. Parents were asked to identify the special dietary needs of their children at more than one half (53.5 percent) of the home base programs. Individualized plans to satisfy the special dietary needs of the children were formulated at 18 home base centers.

One way for parents to learn about what their children are eating is to take meals with their children at the centers. Nearly three quarters of the centers reported that parents ate meals at the program within the month preceding the survey.

Nutrition education for parents was provided by 30 home base programs. In addition to classes, parents were educated by individual counseling and pamphlets. More than one quarter (27.9 percent) of the programs hold these sessions at least monthly.

b. Parent-Originated Data

According to parents interviewed, most of the children (97 percent) ate breakfast at home base centers. All but one of the children ate lunch at the centers. The evening meal was eaten at home by 87 percent of these children.

Over three fifths of the parents interviewed had seen menus of food served to their children at the programs. The food served was generally liked by 87 percent of the children, according to parents.

A little more than two fifths of the parents reported that someone from the center had contacted them about their child's eating habits. Finally, one fifth of the parents had been contacted by someone from the center to discuss the buying or preparing of food.

C. PRESENCE OF A BILINGUAL/MULTICULTURAL LEARNING ENVIRONMENT AT MIGRANT HEAD START CENTERS

For the majority of the Migrant Head Start programs' target population, English is a second language. In most of these cases, the mother tongue is Spanish. It is the language of choice for many migrant children, and it may be the only language in which they can communicate. Other minority elements in the target population also speak what, for most Americans and for the public school system, is a foreign language. The cultural origins of this segment of the target population are also outside the mainstream American culture. The same is true, to a lesser degree, for black children who enter migrant programs. One objective of all Head Start programs is that language use and activities at learning centers both (1) reflect the home and community life of the children enrolled and (2) introduce children to the language, cognitive skills, and behavior models that will enable the student to adapt to and succeed in the public school system.[46]

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[46] "Head Start Performance Standards," OCD-HS Head Start Policy Manual, OCD Notice N-30-364-4, pp. 7, 9.

In terms of language, this means that children who do not speak English should be able to speak their own language, to be understood by adults directing activities, and to participate in center activities in this medium. At the same time, the child should be taught to speak, to write, and to acquire prereading skills in English.

In the cultural sphere it means that such things as foods and food preparation, holidays celebrated, and stories told in the classroom should (1) reflect the cultural traditions of children whose heritage is separate from those of mainstream America and at the same time (2) introduce these children into the cultural values and practices which predominate in the public schools of our society.

The need for a bilingual/multicultural learning environment at Migrant Head Start centers and evidence of the presence of these environments is described below.

1. Measures of the Need for Bilingual/Multicultural Staff, Materials, and Activities

a. Number of Children Whose Primary Language Is Not English

At the time of the survey, three quarters of all children enrolled in Migrant Head Start home base programs were Hispanic. This does not necessarily imply that the first language of these children was Spanish. Two measures of the language normally used by each child sampled were taken in the study. Parents were asked how frequently English, Spanish and any other language were used at home. And, the Bilingual Syntax Measure (BSM) test was given to each child to determine proficiency levels in English and Spanish.

As Table 93 below demonstrates, Spanish was used in the homes of most Hispanic children in Migrant Head Start home base programs.

TABLE 93

PERCENTAGE OF HISPANIC FAMILIES USING SPANISH AT HOME ACCORDING TO PARENTS

Grantee	Hispanic Enrollment	Hispanic Families Using Spanish at Home Most of the Time
FFC	32.0%	82.7%
ECMP	50.0%	66.7%
SWGA	2.6%	100.0%
TMC	99.8%	88.9%
MOP	100.0%	90.1%
CUI	94.7%	92.3%
TOTAL	75.2%	86.5%

Table 93 indicates that 86.5 percent of the Hispanic children's families sampled almost always used Spanish in their homes. This group comprised almost two thirds (65 percent) of all children enrolled.

According to language dominance scores on the BSM, approximately the same percentage (88.1 percent) of Hispanic children sampled from Migrant Head Start home base centers spoke Spanish as their primary language. (See Table 94.)

TABLE 94

COMPARISON OF SPANISH LANGUAGE DOMINANCE SCORES FROM THE BSM OF HISPANIC CHILDREN ENROLLED*

Grantee	Percentage of Enrollment Hispanic	Percentage of Hispanic Enrollment Spanish Dominant	Percentage of Hispanic Enrollment Spanish Monolingual	Total Percentage of Hispanic Enrollment with Spanish as a First Language
FFC	32.0%	27.3%	72.7%	100.0%
ECNP	50.0%	6.7%	13.3%	20.0%
SWGA	2.6%	100.0%	-	100.0%
TMC	99.8%	6.0%	90.0%	96.0%
MOP	100.0%	9.7%	90.3%	100.0%
CUI	94.7%	22.2%	72.2%	94.4%
TOTAL	75.2%	11.9%	76.2%	88.1%

*A BSM dominance level was impossible to determine for 44 percent of the Hispanic children sampled. A child must be proficient at an intermediate level (Level 4) in at least one language in order to determine language dominance.

As Table 94 demonstrates, three quarters (76.2 percent) of the Hispanic children sampled for whom language dominances could be determined were Spanish monolingual and 11.9 percent were Spanish dominant. Both groups require access to teachers and other staff who speak Spanish if they are to understand and join in the activities at the programs.

b. Centers Where a Bilingual/Multicultural Learning Environment Is Required for the Children

The language primarily used at home and language dominance scores are two measures of the need for bilingual activities. However, the cultural heritage of the children, regardless of language, must also be taken into account. This consideration applies equally to black and Hispanic children who, when combined, comprise over 95 percent of all children enrolled in Migrant Head Start home base programs. All Migrant Head Start home base centers had a majority of either black or Hispanic children. (See Table 95.)

TABLE 95
DOMINANT ETHNIC GROUPS AT HOME BASE CENTERS

Grantee	Centers with Hispanic Majority	Centers with Black Majority	Total Number of Centers
FFC	5	9	14
ECMP	3	2	5
SWGA	-	2	2
TMC	20	-	20
MOP	1	-	1
CUI	1	-	1
TOTAL	30	13	43

Seventy percent of the 43 centers served a majority of children who came from Hispanic cultural backgrounds. Since nearly all Hispanic children enrolled in Migrant Head Start home base programs were Mexican-Americans, the Mexican culture was the dominant Hispanic culture at these centers.

The majority of children at the remaining 30 percent of the Migrant Head Start home base centers were black. Cultural activities relevant to the black heritage were appropriate in these programs.

At several centers in the Southeast, more than one ethnic group was represented in substantial numbers. In the ECMP and FFC centers, these groups were black and Hispanic. The mix was between black and white children in the SWGA programs.

2. Measures of the Existence of a Bilingual/Multicultural Learning Environment at Centers

Five factors were explored to determine the existence of bilingual/multicultural learning environments: curricula used; language used in classrooms; ethnicity of staff; languages of staff; and other measures of multiculturalism at centers.

a. Curricula

Grantees with a sizable proportion of Spanish-speaking children (CUI, MOP, and TMC) accommodated this need through the use of a bilingual curriculum. All three grantees made use of the Bilingual Early Childhood Program (BECP). At Campesinos Unidos, the BECP had been integrated into an educational program developed by the grantee. The BECP was used and supplemented with a goal kit at the MOP center. And all centers operated by TMC used the BECP.

The other three grantees (FFC, ECMP, and SWGA) had predominantly English-speaking enrollees and often required no specific bilingual curricula. There was some indication at the centers with Spanish-speaking children, however, that the curriculum being used was translated by a staff member.

b. Language Use in Classrooms

Language use in the classrooms by the teacher generally followed the same pattern as the language of choice of the children. (See Table 96.)

TABLE 96

LANGUAGE USED BY TEACHERS AND CHILDREN IN HOME BASE PROGRAMS

	Teachers			Children		
Grantee	English	Spanish	Both	English	Spanish	Both
FFC	6	-	8	6	1	7
ECMP	2	-	3	2	-	3
SWGA	2	-	-	2	-	-
TMC	-	8	12	-	10	10
MOP	-	1	-	-	1	-
CUI	-	-	1	-	-	1
TOTAL	10	9	24	10	12	21

In the majority of programs (55.8 percent), teachers give directions and instructions in both English and Spanish. Children used both languages in the classrooms at nearly one half (48.8 percent) of the centers. At three centers children continued to use Spanish only, while teachers used both Spanish and English.

c. Ethnicity of Staff

Another indicator of a bilingual/multicultural learning environment is the presence of staff who share the language and cultural heritage of minority children enrolled. As Table 97 below demonstrates, on a grantee by grantee basis, staff generally reflected the ethnicity of children enrolled.

TABLE 97
ETHNICITY OF CHILDREN AND STAFF AT HOME BASE CENTERS

	Hispanic		Black		White		Asian	
Grantee	Children	Staff	Children	Staff	Children	Staff	Children	Staff
FFC	32.0%	35.6%	66.0%	56.9%	2.0%	7.5%	-	-
ECMP	50.0	33.0	40.8	42.0	9.2	25.0	-	-
SWGA	2.6	-	57.4	52.0	40.0	48.0	-	-
TMC	99.8	99.6	*	-	*	-	-	-
MOP	100.0	58.3	-	-	-	41.7	-	-
CUI	94.7	92.4	-	3.8	5.3	-	-	3.8
TOTAL	75.2%	65.0%	21.4%	25.0%	3.2%	9.8%	-	0.2%

*Less than 0.1%.

There were, however, proportionally fewer Hispanics (ten percent) working at home base programs than there were children enrolled. There were proportionally more black staff than black children enrolled. The same was true for whites, but the overall number of both white staff and enrollees was extremely low.

d. Spanish-Speaking Staff and Children

As the following table shows, the proportion of Spanish-speaking staff at the centers was roughly equivalent to the proportion of Spanish-speaking children.

TABLE 98

COMPARISON OF SPANISH-SPEAKING STAFF WITH CHILDREN WHOSE PRIMARY LANGUAGE IS SPANISH

Grantee	Percentage of Spanish-Speaking Staff	Percentage of Spanish-Speaking Children
FFC	23.0%	29.6%
ECMP	25.0	32.8
SWGA	-	5.7
TMC	87.0	88.9
MOP	87.0	90.1
CUI	94.0	92.3
TOTAL	57.0%	53.6%

In fact, there were proportionally more staff who spoke Spanish than children at home base programs.

e. Measures of Multiculturalism at Centers

Elements of the culture of the migrant child were often brought into the classroom at the migrant home base sites. Foods reflecting the migrant child's background, stories, music and games, and the celebration of ethnic holidays were part of the overall environment of many centers. (See Table 99.)

TABLE 99

INDICATORS OF MULTICULTURALISM AT HOME BASE CENTERS*

Grantee	Centers Serving Culturally Relevant Meals	Centers Using Stories, Music, Games
FFC (N=14)	71.4%	85.7%
ECMP (N=5)	100.0	100.0
SWGA (N=2)	50.0	100.0
TMC (N=20)	90.0	90.0
MOP (N=1)	100.0	100.0
CUI (N=1)	100.0	100.0
TOTAL (N=43)	83.6%	72.1%

*Percentages are for centers using culturally relevant foods, stories, and music and games at least weekly.

Overall, 83.6 percent of the programs served foods that reflect the migrant child's culture at least once a week. Stories, music, and games which relate to the cultural heritage of the migrant child were made part of the educational environment at 72.1 percent of the centers.

Cultural events and holidays related to the migrant child's culture were observed at 86 percent of Migrant Head Start home base centers.

D. OTHER ADMINISTRATIVE POLICIES AND PRACTICES ADAPTING PROGRAM OPERATIONS TO SPECIAL USER NEEDS

Because of the itinerant nature of migrant life (and contributing factors such as language barriers and limited education), migrant parents are often unaware of the presence of Head Start centers and fail to take advantage of the service they provide. Therefore, IMPD has stated that programs should make special efforts to seek out migrant children and families most in need of help and draw them into the program.

IMPD has also directed its grantees to operate programs in the same location for a minimum of three months. This guideline is based on the assumption that operating a program for a shorter period of time is not cost-effective.

Grantees are asked to provide flexible services which are adapted to other special needs. Program hours are to be extended, when necessary, to match the hours parents work in the fields. Programs are to be designed to accommodate and care for infants and toddlers as well as preschool children. They are also to be prepared to accommodate unpredictable fluctuations in numbers of enrollees.

1. Providing Services to All Preschool Children, Regardless of Age, During the Work Season

Migrant Head Start home base programs responded to the need for enrolling children under three years old especially during the work season, in the following ways:

- Three fifths of all programs served children under three years of age;
- One out of five programs served more than ten children under three years; and

- The other two fifths of all programs served between one and ten children under three years old.

Florida Farmworkers Council, East Coast Migrant Head Start Project, and Texas Migrant Council operated centers which reported enrolling this age group of children. East Coast operated two centers for infants and toddlers only.

Some programs required children younger than three years old to have an older sibling enrolled in the program. This was true for 15 percent of the centers which enrolled children under three years old.

Overall, 12 percent of the children from home base programs were under three years of age, according to center directors.

2. Offering a Minimum of Three Months' Service and Extending Hours to Serve Working Parents

IMPD Guidelines indicate that regular Head Start services should be provided with modifications including the extension of full day services and the capability of providing a minimum of three months of services.

All Migrant Head Start home base programs were open for at least 90 days except three centers operated by TMC. Most programs were open between eight and nine hours a day. All centers operated five days a week.

When asked about their working hours, parents interviewed provided the following information:

- Fathers of one third of the children sampled worked 40 hours a week;

- Fathers of one quarter of these children were working more than 40 hours a week;
- One third of the mothers of children sampled were working 40 hours a week; and
- About six percent of the mothers were working more than 40 hours a week.

Parents were asked about the convenience of the hours of home base programs. Ninety-five percent reported that the schedule was convenient for them. The most common complaint (by 3.4 percent of respondents) was that the centers should open earlier.

3. Outreach and Recruiting Activities

In general, home base programs were filled to 85.5 percent capacity. According to center directors, the centers, which were funded to serve an average of 68 children per site, were actually authorized to enroll 72 children. The average enrollment per center at the time of the survey was 58 children.

Over one half (53.5 percent) of the programs maintained a waiting list. A total of 360 children were on waiting lists, or an average of 16 children at centers keeping lists. A total of 560 children had tried to enroll without success since the centers opened. This suggests that an average center would have had to enroll 13 additional children to accommodate all children who had sought to enroll.

IMPD's eligibility criteria were met by 76.5 percent of the children enrolled in home base programs according to information provided by center directors.

Seven programs did not follow a policy of enrolling all children meeting minimum IMPD requirements on a first-come, first-served basis. Handicapped children, children from needy families and children previously enrolled at the center were given preference at these centers.

Social service providers were asked what methods were used to recruit children, and what percentage of all enrollees were recruited by each method cited. Table 100 shows the responses to these questions.

TABLE 100

NUMBER OF CHILDREN RECRUITED BY VARIOUS METHODS AT HOME BASE CENTERS

Method	Number of Children	Percentage of All Children
Visits to parents' homes	612	23.6%
Radio, newspaper or television messages	203	7.8%
Posters or billboards	152	5.8%
Community meetings	100	3.9%
Telephone or personal contact with community leaders	79	3.0%
Other	93	3.5%

Nearly one quarter of all children enrolled were recruited through visits to parents' homes.

Almost one fifth of the children sampled (63 families) had brothers or sisters who also attended Migrant Head Start home base programs at the time of the visits. Approximately one third of the children had a brother or sister who had attended the same program in the past.

Nearly one half (43.3 percent) of the parents interviewed reported that they heard of the Migrant Head Start programs by word of mouth from friends or relatives.

The most common response from parents asked why they decided to send their child to the Migrant Head Start program was that it prepares the child to do well in school. Over three fifths of the parents (61.5 percent) gave this response. Nearly all of the remaining parents looked on center programs mainly as a source of child care for their children while the parents were working.

4. Some Comments on Administrative Policies and Practices Adapting Program Operations to Special User Needs

Program adaptations called for in the IMPD Guidelines apply particularly to MHS centers operating during the work season. Since the work season during the months from October to May varies widely across home base States, it should be expected that these adaptations would occur only where and when applicable.

The orange harvest in Florida, for example, certainly provides work opportunities for farmworkers in home base areas. In Texas, farmworkers find jobs in the vegetable harvests in the Winter Garden and Rio Grande Valley regions.

In general, as outlined above, Migrant Head Start home base programs in these areas had made some of the same modifications that are often required during the work season.

On the other hand, other data suggests that the need for special program modifications at home base sites operating during the winter months was limited. For example, 87 percent of the fathers and 56 percent of the mothers were working. But only 26 percent of fathers and six percent of the mothers interviewed reported working more than 40 hours a week.

A limited number (seven percent) of parents suggested that current program hours be extended. But these parents recommended only that programs begin from 15 to 30 minutes earlier or extend services up to a half hour longer in the afternoon; none recommended that a program open on Saturday. This suggests that some of the more extreme program modifications which may be required during the summer work season were not needed at home base sites. It is expected that the need for more radical and innovative program modifications will surface in the Phase II study of destination area programs serving migrant families who are in-stream.